

LANGUAGE AND CULTURE IN HEALTH CARE

Coping With Linguistic and Cultural Differences:

Challenges to Local Health Departments

**The United States Conference of Local Health Officers
The United States Conference of Mayors
January, 1993**

The United States Conference of Local Health Officers

The United States Conference of Local Health Officers, an affiliate of The U.S. Conference of Mayors, represents urban health departments, including city, city-county, and district agencies. Founded in 1960, The U.S. Conference of Local Health Officers promotes the local perspective on national public health policy before Congress, the Administration and various federal agencies. It promotes communications among local health departments and their federal and state counterparts and the exchange of information and ideas among local health officers. It also provides technical assistance through meetings, conferences, and publications.

Guadalupe Olivas, PhD
President, USCLHO
Director of Health
Pima County Health Department

J. Thomas Cochran
Executive Director

The United States Conference of Mayors

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William J. Althaus
President
Mayor of York

J. Thomas Cochran
Executive Director

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United States Conference of Local Health Officers

1620 Eye Street, Northwest • Washington, D.C. 20006 • (202) 293-7330

FOREWORD

The United States as a nation is failing to address the needs of millions of its citizens for basic good health. The problem has engaged the attention of a new Administration and Congress in Washington. As we reassess this most basic of human needs, we need to address at the same time the special problems of millions of us who speak little or no English. We need to imagine for a moment how much more difficult it is for someone from another culture—someone who cannot speak or understand English or who does poorly at best, someone whose language problem is, more often than not, compounded by poverty and racial and ethnic discrimination—to gain access to health care in the United States.

The problem is a very real one. It presents a difficult challenge to local health departments, health care practitioners and providers nationwide. As this report notes, even the most basic routine daily tasks can be difficult, even overwhelming, for someone to whom the prevailing language and culture are foreign. How much more traumatic must it be if someone is sick and in need of medical attention!

The numbers of people in this circumstance in this country have been growing dramatically in recent years. The 1990 Census calculated that over 6% of the U.S. population—almost 14 million people—lack proficiency in English. The estimate is most certainly low, but programs designed to meet the health care needs of those of us who are not fluent in English are lacking. If those needs are not addressed, they will eventually place everyone at risk.

In this report the United States Conference of Local Health Officers (USCLHO) addresses this growing national problem, the challenges it brings to local health departments, examines how some are coping with it, and recommends actions appropriate to local health departments and to Federal policymakers as well.

We recognize the immense contributions being made by thousands of dedicated health care workers who deal with these problems every day, generally with woefully inadequate resources, in cities and towns across the country. We hope this report will stimulate concern about the tasks they face and lead to policies which will generate the help they so urgently need and certainly deserve.

J. Thomas Cochran
Executive Director
The United States Conference of Mayors
The United States Conference of Local Health Officers

Guadalupe S. Olivas, PhD
President
The United States Conference of Local Health Officers

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EXECUTIVE SUMMARY

As the ability of this country to meet the most basic health care needs of its people is reassessed, the impact of the dramatic influx of immigrants, particularly in the last decade, must also be addressed. Many of these immigrants have only a limited knowledge of English or do not speak English at all. They come from a multitude of cultural backgrounds, lack health insurance, have little or no income, and, along with millions of other minorities, lack adequate access to health care. For someone who does not understand English, even the most basic of routine daily tasks can be overwhelming and traumatic when more urgent health concerns exist.

At issue is the ability of many health programs and health practitioners to work with populations of ever-increasing diversity in both language and culture. To promote access, medical care must be available in many different languages and must be provided in culturally-connected or competent ways to avoid misinterpretations and possible social offenses that can alienate individuals further from the public health system.

The response of the nation's local health departments (LHDs) to the needs of limited/non-English speakers is highly uneven and is largely defined by a number of factors:

- the type of structural and financial arrangements within a given jurisdiction (i.e., city, county, city-county, district; urban, suburban or rural);
- the type of public health care services traditionally provided in that locality, ranging from core public health services to extensive direct services;
- the diversity of languages spoken in that locality, the migration patterns and demographic characteristics of the limited/non-English speaking population; and,
- the local history of, and experience in, providing health services to limited/non-English speaking persons.

The United States Conference of Local Health Officers (USCLHO) addresses in this document the numerous obstacles encountered at the local level to the provision of services to limited/non-English speaking groups and provides recommendations for action to be taken by both local health departments and Federal health policymakers.

The document contains three main sections:

- 1) a review of the literature on issues related to the impact of languages other than English as spoken by clients who access local health care;
- 2) a report on the findings from a 1992 USCLHO survey of LHDs to gauge the status of local health services specifically targeting limited/non-English speakers; and,

- 3) a series of case profiles portraying specialized LHD programs that seek to improve access to health services for linguistic minorities in seven urban areas.

FINDINGS:

Taken as a whole, the major findings of the literature review, survey and case profiles suggest that:

- While local health departments are aware of the need to increase health care access for linguistic minorities, there is generally limited knowledge and experience in addressing specific problems encountered by those minorities and limited mechanisms in place at the local level to meet the growing demand;
- Many LHDs face budgetary dilemmas and therefore cannot afford to hire multilingual/multicultural staff, conduct needs assessments, provide linguistic-specific services, operate extended hours, or conduct language-sensitive outreach;
- Across LHD jurisdictions in the sample, health information is not commonly available by race/ethnicity for the major limited/non-English speaking groups;
- LHDs in large cities with large non-English speaking (NES) populations are most likely to provide targeted services;
- Less than a quarter of responding LHDs have conducted a needs assessment for a specific NES population;
- Access to health care is diminished for large segments of ethnic minority populations who are educationally and economically disadvantaged;
- An increase in the number of health care professionals from minority cultures would facilitate improved service delivery to their communities. This is a significant finding, for most LHDs indicated they have difficulty recruiting bilingual and bicultural staff, especially in large cities with large populations of NES; and,
- The most important assistance LHDs could receive would be in the identification and recruitment of bilingual staff, information on the current patterns of utilization of health services by NES, and assistance on how to make programs and services more accessible and acceptable to those clients.

RECOMMENDATIONS:

The further development of adequate efforts to reach NES populations will require the specific allocation of resources and the planning and design of targeted strategies. This study suggests that health agencies and health providers should:

- Identify at the local level specific language and cultural differences by national origin in data collection, service delivery and needs assessments by local health providers;

- Identify appropriate health data information categories and develop strategies for retrieving that data at the local level so as to capture patterns of health service utilization by NES populations;
- In relation to interpreter utilization, conduct further research to assess current LHD policies in traditional appointment systems and protocols for walk-ins;
- Develop, identify and implement models of community needs assessments which are culturally and linguistically relevant and will be effective and feasible in both large and small cities;
- Develop, identify and implement cross-cultural training models which are applicable to several different health care systems;
- Identify the qualifications necessary for bilingual and bicultural local health provider staff, and develop specific strategies to recruit, train and retain that staff;
- Develop a model which utilizes community health advocates and special training to assist LHDs and local health providers in breaking the barriers of access due to language, race and ethnicity; and,
- Develop a health training program to support/ensure an increase in NES certified health providers.

INTRODUCTION

The public health issues we face today are not simply medical issues. They are social, cultural and political issues that require a broad, but compassionate approach. For the millions of immigrants, refugees, the documented/undocumented and those generations of non-English speakers (NES) who have lived in this country for many years and who have limited or no ability to speak English, language is another barrier, to be added to socioeconomic and legal status, to health care and proper utilization of health services.

According to the 1990 Census significant percentages of large urban area residents indicate that they cannot speak or understand English very well. This inability fully to understand and communicate effectively in English often prevents many NES in this country from accessing essential medical services. This situation is further frustrated by the current shortage of trained bilingual/bicultural medical staff and health care providers.

To explore issues of the unique linguistic needs of limited/non-English speakers who access health care services, an interagency program was established in 1991 among the Association of State and Territorial Health Officers (ASTHO), the National Association of County Health Officers (NACHO), and the United States Conference of Local Health Officers (USCLHO).

To examine the problem at the level of the local health jurisdiction, USCLHO developed the Multilingual Health Assistance Project (MHAP), as part of the Minority Health Initiative. Through the project USCLHO seeks to raise local health department (LHD) awareness about issues that relate to language barriers in health care access and provide information to LHDs on effective approaches to address multilingual health needs.

USCLHO works with a National Advisory Group (NAG) comprised of local health officers and representatives of national organizations which represent the health interests of NES populations. The NAG provides general guidance and advice to the project and helps develop recommendations on how local health systems could become more responsive to the health care access needs of limited/non-English speaking populations.

The goals of the Multilingual Health Assistance Project are to:

- Identify the best practices in local health systems that address bilingual health care needs in cities;
- Help build consensus among local health providers and other key sectors, including representatives of linguistic groups, on ways local health systems can be more responsive to the needs of NES populations; and,
- Disseminate information which would facilitate the expansion of those types of responses in communities across the country.

USCLHO's MHAP issued a nationwide survey during March and April 1992 to assess the status of health care services to limited/non-English speaking populations among 566 LHDs. This information was supplemented by telephone interviews with LHD officers and directors of bilingual programs.

The initial MHAP survey was based on a questionnaire designed for USCLHOs Minority Health Initiative. To assess the services for limited/non-English speakers in LHDs, the instrument was re-designed to examine specific activities and practices associated with facilitating access to services and to assess opinions regarding perceived barriers to services and technical assistance needs in this area. The survey was pre-tested with the help of the National Advisory Group.

As described in the document, communication, treatment, and education are the most important areas for continued work in improving and implementing programs and strategies that address the importance of culturally-sensitive health care. This is important since there are numerous cultural communities in the U.S. with distinctive characteristics and requirements.

There is also a need to monitor the means by which cultural and linguistic issues in health care are addressed. Appropriate needs assessment and evaluation technology is needed to further understand the populations involved, and to help them overcome existing barriers to health care services.

The case profiles in the document illustrate methods LHDs have taken to address and improve health services for various linguistic populations. The methods range from outreach programs to cross-cultural programs to interpreter services. The issues of communication, treatment, and education in culturally-sensitive health care at the local level are important elements in these LHD profiles. After all, it has been the LHDs, particularly in the last decade, that have felt acutely the dramatic influx of immigrants with limited or no knowledge of English.

LITERATURE REVIEW

Overview

The U.S. Census estimated that as of 1990, over 6% of the U.S. population was not proficient in the English language. Over 40 million people belong to ethnic groups associated with languages other than English. However, programs and strategies aimed at addressing the health care needs of populations with language and cultural differences are often significantly lacking. Unaddressed, the health needs and risks these populations experience will eventually have an impact on the broader community. Research aimed at better understanding the special needs of these communities is essential in developing methods of outreach in health education and in effective health care delivery. Health care providers are in an optimal position to provide a bridge for these growing communities, but they can only succeed where effective communication and treatment vehicles are in place.

To bridge language and culture barriers in health care, it is necessary to understand those factors that may create obstacles in the effective delivery of health services. To accomplish this will require the research and input of many, and the insights and feedback of health-related agencies and providers at the Federal, state and local levels.

In reviewing the available literature on issues related to health care delivery to non-English speaking (NES) and culturally diverse populations, we found valuable insights about specific issues pertaining to multilingual assistance efforts. A number of authors have emphasized the diversity that exists within the commonly defined cultural and ethnic groups. Beyond specific cultural considerations, this diversity is also dictated by social and economic factors operating regardless of ethnic background, but which influence the “cultural” nature of ethnicity. Recent research points to a strong relationship between the socioeconomic factors that influence access to health care and the degree to which language and cultural barriers may exist.

The literature review outlines specific areas of interest to our current research effort that were used as a framework for the interpretation of the survey results, and that provided focus and direction to USCLHO’s Multilingual Health Assistance Project. While not exhaustive, we believe that our efforts covered a substantial body of information, enough to support our analysis. Certain topics not covered here will hopefully be covered in subsequent research efforts, such as the impact of migratory patterns of the Asian and Pacific Islander communities and recent refugee populations, special needs of growing Eastern European and Baltic communities, and the impact of migrant workers on local health clinics.

Overall, the existing literature suggests that the nation is only at the threshold of understanding the health care needs of NES and culturally dissimilar populations. As would be expected, there is a significant amount of published material about African American populations, and the Hispanic/Latino community. The Native American population is also addressed in numerous publications, possibly due to the longevity of our struggle to address the needs of this population adequately. The recent Asian immigrant populations such as the Vietnamese, Cambodian, and Laotian, are better addressed in articles pertaining to mental health than in those dealing with other types of health care delivery. Similarly, refugee issues in the literature are usually framed in terms of Southeast Asian populations. Information on other groups, such as Haitians and African immigrants, is very limited.

We sought to find topics relating to health care education, outreach programs, prevention, and treatment of NES groups. This search included university libraries, professional organizations, the National Institutes of Health, and other researchers with similar interests. These findings are presented in the hope that they may serve to further the understanding of culturally diverse populations and their health care needs.

A REVIEW OF LANGUAGE AND CULTURE IN HEALTH CARE

The United States has often been described as a “nation of immigrants.” The United States has also been characterized as both a “mosaic” and a “melting pot” of cultures. Ethnic, cultural diversity and cultural change continue to be dominant elements in American life. Ethnic groups identified by the U.S Census as associated with NES cultures represent a significant component of the U.S populace. Together, these groups totaled over 40 million people in 1990 -- 16% of the national population. Over the last decade the “Hispanic” population has grown by over 50% to 22.4 million, while the “Asian and Pacific Islander” group has nearly doubled to 7.3 million persons. Other ethnic minorities have also grown dramatically in recent years. For many among these ethnic and immigrant populations, “acculturation into mainstream America” can be a difficult and incomplete process (Kirkman-Liff and Mondragon, 1991; Bills, 1989; Randall-David, 1989).

The barriers to effective health care affecting many within the growing racial/ethnic minority populations of the United States represent an important public health issue. Although data relating to the health of cultural minorities are sparse, “many clear differences in the health status of ethnic groups have been identified” (ASTHO, 1992:1).

1990 Census data indicate that significant portions of our ethnic populations are not proficient in English. In California, Texas, New Mexico, New York, and New Jersey, which contain large, primarily urban, ethnic populations, over 10% of the total state populations reported that they “do not speak English very well.” The Association of State and Territorial Health Officials (ASTHO) notes that the “ability to speak the language of health providers has been shown a stronger predictor of use of health screening services than ethnic identification in the U.S.” (ASTHO, 1992:2). ASTHO also states that it is language “in combination” with cultural, structural, and financial barriers that “impede access to health services” for ethnic groups. This brief review will focus on recent work which has been directed towards understanding and minimizing the impact of cultural and linguistic barriers to health care. These issues warrant the increased attention of the health care community and related government agencies at all levels.

Issues in Cross-Cultural Health Care

A study of health care issues relevant to the ethnic communities in Seattle, conducted by the Pacific Medical Center (PMC) and the Committee for Cross-Cultural Care, summarized the issues influencing health care service to cultural minorities in four categories as follows:

- Differences in language and non-verbal communication patterns present major barriers to effective care.
- Cultural differences in perceptions of illness, disease, medical roles and responsibilities can cause misunderstanding and mistrust.
- Differences in cultural preferences can render Western treatment plans irrelevant to the patients’ needs.

- Differences in socioeconomic status limit access to needed services (PMC Study, 1991).

The socioeconomic issues that influence access to health care for all people in the U.S. can be compounded for ethnic populations by cultural factors. It is important to understand, however, that a great deal of variation can exist within each of the commonly categorized "ethnic" or "culture" groups. While relatively broad groupings such as "Hispanic" or "Asian" may be useful in describing general commonalities, significant subgroup and individual variations exist (Randall-David, 1989; Shur et al, 1987; Chang, 1981). Within each of the culture groups which contain the greatest percentage of recent immigrants, a diversity of "exposure to dominant Anglo standards and behaviors" (Randall-David, 1989) contributing to levels of acculturation is present. Generally, the degree of each individual's assimilation of the dominant culture will help determine the degree to which barriers are likely to exist. Elizabeth Randall-David outlines a number of factors influencing this relationship:

- 1) a relatively high level of formal education, probably a minimum of several years of high school;
- 2) birth into a family that has lived in the United States for several years;
- 3) extensive contact with people outside their ethnic and/or family social network;
- 4) for immigrants, immigration into the U.S. at an early age;
- 5) urban, as opposed to rural, origin;
- 6) limited migration back and forth to the mother country;
- 7) higher socioeconomic status.

Other factors influencing individual differences are age, sex, occupation, social class, religious affiliation, and family size (Randall-David, 1989:3).

Garland D. Bills' study of the Spanish language population in the southwest United States based on the 1980 Census tends to support many of these perspectives with regard to language adaptation: "...[M]aintenance of Spanish is highest where the Hispanic population is characterized by low income, limited education, and residential stability". A predominant shift to English among the Hispanic/Latino population occurred in "counties without a strong Hispanic presence where the Spanish origin population is younger, wealthier, more educated, and residentially mobile -- and where wives work more outside the home" (Bills, 1989: 25-26).

Kirkman-Liff and Mondragon confronted the relationship between language and health status directly by allowing Hispanic/Latino survey respondents in Arizona to choose the language in which the survey would be administered. They then analyzed the results of the survey, which provided measures for various health care and socioeconomic factors, controlling for the language chosen. They found that: "Hispanics who were interviewed in Spanish have lower health status and worse access to care than Hispanics who were interviewed in English, before consideration of other demographic variables" (Kirkman-Liff and Mondragon, 1991:1401), but that "Spanish monolingualism, in itself, is not a health risk factor, but a practical indicator of important risk factors such as diminished education, poverty and diminished access to care" (Kirkman-Liff and Mondragon, 1991:1403).

These authors suggest that language and culture co-vary with socioeconomic status within ethnic groups. Therefore, to the extent that members of immigrant and ethnic groups tend to retain language and culture traits, they also tend to be socially and economically disadvantaged. These groups therefore face a two-fold barrier in obtaining adequate health care.

Socioeconomic Issues in Health Care

Healthy People 2000 reports that "...health disparities between poor people and those with higher incomes are almost universal for all dimensions of health" (PHS, 1991:29). Rates of infant death, developmental limitations, chronic disease, and traumatic death demonstrate a clear relationship to social and economic status. Many of the risk factors associated with health are associated with poverty status. Obesity, high blood pressure, and tobacco use have been linked to education and income levels.

A serious barrier to health care for those in low income groups is inadequate health insurance coverage. The Public Health Service reports that "...as of 1986 15% of persons under 65 had no health insurance, from either public or private sources. This compares to 37% for those families that had incomes below \$10,000 annually. More recent information indicates that in 1989, over 33 million persons in the United States, or 14% of the population, had no health insurance. In addition, while 78% of White persons had private health insurance, only 54% of Blacks, and 50% of Hispanic Americans had privately provided coverage" (U.S. Census, Current Population Survey, 1990 reported in Chelimsky, 1991:10).

Eleanor Chelimsky reports that this discrepancy exists regardless of employment status. "In families with adult workers, only 57% of Hispanic compared with 69% of blacks and 84% of whites have private insurance coverage" (from National Center for Health Services Research and Health Care Technology Assessment, NMES, Round 1, 1987). Chelimsky notes that the insurance disparity experienced by Hispanic/Latinos is associated with the types of employment and income levels that predominate among Hispanic/Latino Americans. She reports that 78% of uninsured Hispanic/Latinos are employed. "Hispanics with low incomes...were much more likely to be uninsured than those with higher incomes. This situation probably reflects income differences among employment sectors, differential coverage between occupational levels, and differing capacity to afford the purchase of individual health insurance policies" (Chelimsky, 1991:14). Clearly, health status within ethnic and culture groups can vary with both socioeconomic and cultural factors.

Cultural Issues in Health Care

Delgado, Metzger, and Wilkes provide this elucidating view of the role of cultural barriers to health care:

...[I]magine yourself in need of health care in a part of the world where you don't understand the language spoken and very few of the locals understand the language you speak. The values and beliefs of the local population are much different from your own and your physical characteristics cause you to stand out from the crowd. The locals regard your presence as a burdensome annoyance as some openly demand that you go back where you came from. Even though you are a major contributor to the

growth of the local economy, they consider you a drain on the system. Worse yet, all the services you have come to depend on such as government, the educational system, and health care are based on the values and beliefs of the locals and seem hopelessly bureaucratic to you. When you enter a health care center the person at the desk starts talking to you in a very loud voice because they think that you will understand them better. Then they give you many forms to fill out in a language that you do not read. As the time passes they give you more papers to sign. Your family is told to stay behind while they take you into a room where you wait for more than an hour. Your name is called and you are brought into a large room and told to take off your clothes and put on a paper gown. You spend six minutes with one person and seven minutes with someone you assume to be a health care provider. You leave with pieces of paper in your hand and several bottles of pills. As you walk away you decide that perhaps it is better if you just take care of yourself and avoid having to go back to this place unless you are very ill (Delgado et al, 1992:9).

The Language Barrier - Interpreters

Certainly, the health care system can be alienating even without the strain caused by cultural and linguistic barriers. Once within the clinical setting, a language barrier must often be dealt with through an interpreter. A number of authors have discussed the importance of the interpreter's role in bridging cultural and linguistic gaps within the medical setting (Randall-David, 1989; Diaz-Duque, 1989; Putsch; 1985, Grasska and McFarland, 1982; Diaz-Duque, 1982). While "monolingual providers and staff need training to learn the implications of both language and cultural barriers" (Putsch, 1985:3347), "interpreters must be sensitive to sociolinguistic and sociocultural differences between patients and health care providers" (Diaz-Duque, 1989:101). Randall-David offers a comprehensive summary of issues important to the selection of interpreters:

1. Ideally an interpreter should be someone who is:
 - trained in cross-cultural interpretation;
 - trained in the health care field;
 - proficient in the language of the client and the professional; and,
 - able to understand and respect the culture of the client and that of the health care professional.

These interpreters are ideal because they not only translate the interaction but bridge the culture gap.

2. In the absence of a trained interpreter, use volunteers with training in medical terminology, an understanding of the significance of the particular health matter they will be translating, and an understanding of the importance of confidentiality.
3. Avoid relying on hospital personnel who are bilingual if they have not had some training as interpreters.

4. Be cautious about the use of family members -- especially those of a different age or sex from the client. Clients are often embarrassed to discuss intimate matters with members of the opposite sex or with younger or older members of the family. Family members may wish to shield the client or to keep information within the family.
5. Be sensitive to the clients' right to privacy and their choice of interpreter. Often there are problems when the interpreter is of a different social class, educational level, age, or sex (Randall-David, 1989:31).

Beyond the verbal language issue, there should also be attention and sensitivity to culture-specific meanings which may be associated with body language and other non-verbal behavior (Randall-David, 1989; Diaz-Duque, 1989; Putsch, 1985).

Overcoming the Culture Barrier in Treatment

Each culture has its own system of concepts about the nature of illness and its place in human existence, and these concepts often differ radically from those upon which Western Medicine is based. Success in restoring a person to health can depend in large measure on the practitioner's ability to understand these differences and provide care in a manner that respects the patient's concepts. Failure to accommodate these differences often results in noncompliance and further alienation of the patient from the health care system (PMC Study, 1991: p.3).

Kleinman, Eisenberg and Good outline a culturally generic model for identifying and ameliorating culturally idiosyncratic barriers to medical care. They argue that:

Illness is culturally shaped in the sense that how we perceive, experience, and cope with disease is based on our explanations of sickness, explanations specific to the social positions we occupy and systems of meanings we employ... . How we communicate about our health problems, the manner in which we present our symptoms, when and to whom we go for care, how long we remain in care, and how we evaluate care are all affected by cultural beliefs (Kleinman et al, 1978:252).

They identify the central issue in the cross-cultural medical setting as the "transaction between the patient and doctor explanatory models" (Kleinman et al, 1978:256). The patient model encompasses "the beliefs the patient holds about his illness, the personal and social meaning he attaches to his disorder, his expectations about what will happen to him and what the doctor will do, and his own therapeutic goals" (Kleinman et al, 256). They suggest that the clinician elicit the patient's view through a series of questions:

- 1) What do you think caused your problem?
- 2) Why do you think it started when it did?
- 3) What do you think your sickness does to you? How does it work?
- 4) How severe is your sickness? Will it have a short or long course?
- 5) What kind of treatment do you think you should receive?

- 6) What are the most important results you hope to receive from this treatment?
- 7) What are the chief problems your illness has caused for you?
- 8) What do you fear most about your sickness?

Open comparison of the patient's perspective with the doctor's view "will aid the clinician in dealing with issues relating to conflicting beliefs and value systems" (Kleinman et al, 1978:257). The doctor's model should be imparted to the patient in a simple, direct fashion. The patient is encouraged to ask questions about any perceived inconsistencies between the two views in order to point to issues of concern. "Here the clinician mediates between different cognitive and value orientations. He actively negotiates with the patient as a *therapeutic ally*, about treatment and expectations and outcomes... . This process of negotiation may well be the single most important step in engaging the patient's trust, preventing major discrepancies in the evaluation of therapeutic outcome, promoting compliance, and reducing patient dissatisfaction" (Kleinman et al, 1978:257).

The efficacy of this approach is well summarized by Bullough and Bullough: "A treatment strategy congruent with the patient's own belief system simply has a better chance of success... . The important point to be incorporated into health care knowledge is that treatments that violate strongly held beliefs should not be carried out without coming to terms with those beliefs. The consideration of the cultural variable is crucial" (Bullough and Bullough, 1982: 117).

Education

Culturally-targeted health education and prevention programs have been identified as key factors in improving health care for culturally and linguistically diverse populations (Ginzberg, 1991: Adams, 1990: Randall-Davis, 1989: Delgado, et al, 1992). Educational materials should incorporate the culture and practices of the target community. They should use the language of the target population, but direct translation of existing materials should be avoided as this can result in the conveyance of distorted, inappropriate or meaningless information. Materials should be designed with input from the community and field-tested for appropriateness both in terms of cultural content and communicability. Advertising and outreach efforts should be channeled through media and spokespersons that are known to be effective in the target population.

In Providence, R.I., the Multilingual Health Care Coalition was formed to help overcome problems resulting from declining funds for health-related issues and an increasingly heterogeneous and growing multicultural population. The Providence area has growing Southeast Asian and Hispanic/Latino communities. Community groups from these two populations collaborated with local health care facilities to create and disseminate health care information within both populations. Through evaluation of joint community needs, the coalition selected topics and created videos that addressed culturally-sensitive issues in nine areas of concern. The videos were narrated in several appropriate languages. Although the ideal would have been to generate different tapes for the Hispanic/Latino and Asian and Pacific Islander communities, time and resources constraints precluded this strategy. Despite this shortcoming, post-project evaluation indicated that the program was effective. Involvement of community members in the development and production of the video tapes, with careful consideration of culture-specific issues within both communities, contributed to the success of this program, maximizing scarce resources and improving community relations (Clabots and Dolphin, 1992).

Mental Health Services/Counseling

Sensitivity to cultural issues is critical to the provision of mental health services and counseling. In addition to language problems, poor community awareness of available services, and poor access to services, negative experiences and culturally-based stigma associated with mental health care may cause members of minority culture groups to resist utilization of mental health agencies. Culturally-variable issues in mental health care include: attitudes toward mental health care; verbal expressiveness about personal and family problems; preferred intervention strategies; definitions and explanations for abnormal behavior; time orientation of goals (immediate vs. future); and individual versus group approaches to problem solving (Randall-David, 1989:24). Cook and Timberlake discuss some of these issues with reference to Vietnamese refugees:

Time-limited and work-oriented professional behavior (for example, ending a counseling session just because the allotted time is up) is not understood by Vietnamese refugees. Neutrality and objectivity on the part of a counselor tend to be translated as disinterest, coldness, disrespect, and even betrayal. Moreover, given their emphasis on harmony, many Vietnamese clients have difficulty discussing their problems and sharing feelings and concerns. If a counselor attempts to focus on a client's personal inner world too early in the counseling relationship, the client may abruptly and prematurely withdraw from counseling. By the same token, too abrupt an exit by the mental health counselor from a refugee's support network may be interpreted as betrayal of trust or loyalty. Thus, unless the process of terminating counseling is carefully worked through, this newest loss may undo the goals achieved (Cook and Timberlake, 1989:95-6).

General Characteristics of Major Culture Groups

It is critical to understand that a broad spectrum of sub-group and individual variation exists within the major culture group delineations which are frequently discussed. It is appropriate, however, to discuss generalized culture traits as a baseline for working successfully within culturally-diverse settings. A number of authors have provided views of various culture groups from the perspective of health care (see, for example, Randall-David 1989; Taylor, 1989; Hoang and Erickson, 1985; Bullough and Bullough, 1982; Scott, 1981; Chang, 1981).

According to the 1990 Census, the two largest sub-culture categories for which a potential language barrier exists are "Hispanic" and "Asian and Pacific Islander" groupings. A brief summary of relevant issues and general cultural tendencies for these major groups follows. As Elizabeth Randall-David warns, "...there is always a danger of overgeneralizing or stereotyping when cultural information such as this is described ...[and]...in order to provide effective service to any community of people, service providers must learn about the cultural values and behaviors of the specific community and of individual clients" (Randall-David, 1989:35).

Asians and Pacific Islanders

The U.S. Census indicates that there were approximately 7.3 million “Asians and Pacific Islanders”, or about 2.9% of the U.S. population, residing in the United States in 1990. This represents a doubling from about 1.5 percent of the U.S. population in 1980. This category encompasses individuals whose ethnic backgrounds are rooted in China, Japan, Korea, the Philippines, Southeast Asia, including Vietnam, Laos, and Cambodia, as well as other “Pacific Rim” islands, including Guam and Samoa. There is obviously a great deal of diversity across this broad group. Randall-David identifies a number of factors which can contribute to this diversity:

- Nationality and Heritage
 - Social class and socioeconomic level
 - Age
 - Generation
 - Urban/rural residence in Asia
 - Education
 - Length of time in this country
- (Randall-David, 1984: 41)

Orlando Taylor also identifies some general cultural and communicative behaviors of “Asian and Pacific Islander Americans.” For his view, see Appendix #7.

Generally, traditions within this culture group dictate that health is dependent on maintaining balance and harmony. “Disease, it is believed, is caused by an imbalance, either deficiency or excess, of bodily fluids, airs, or other elements in the universe” (Hoang and Erickson, 1985: 235). Balance within the body is controlled by the opposing forces of “Yin” and “Yang.” Yin, which is female, negative energy, generates cold, wetness, and emptiness. Yang, which is composed of male, positive energy, generates the opposite conditions of warmth, dryness, and fullness. It is held that emotions, diet, or conduct can disturb this balance to cause illness (Randall-David, 1989; Hoang and Erickson, 1985; Campbell and Chang, 1981; Chang, 1981). Campbell and Chang note that some Chinese American patients may consult a practitioner of Chinese medicine and a Western doctor simultaneously. The Chinese practitioner may be an acupuncturist, herbalist or herb pharmacist. They warn that herbal remedies may “contain the same chemical ingredients as Western medicine and might result in an overdose or adverse reaction in the patient” (Campbell and Chang, 1981:165).

Current Status of the Asian and Pacific Islander Populations

As of 1990, the majority of the U.S. Asian and Pacific Islander populations was concentrated in the Western Region, with over 4 million of the 7.3 million Asians and Pacific Islanders residing in these states. Of these, over 95% reside in the Pacific states of California, Oregon, Washington, Alaska, and Hawaii. Asians and Pacific Islanders in the remainder of the country are most concentrated in the highly urbanized Middle Atlantic states. While native-born Asian and Pacific Islander Americans may be “indistinguishable” from the overall American population in terms of health issues, approximately three quarters of the Asian and Pacific Islander population are

immigrants. A great deal of diversity exists across this immigrant population (PHS, 1991). The U.S. Department of Health and Human Services noted in *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* that “an adequate depiction of the health of Asian and Pacific Islander Americans is constrained because data cannot be stratified by subgroups. Many national data systems are unable to make estimates of this minority population because of its relatively small size” (PHS, 1991: 36). Data available from local sources indicate that tuberculosis, hepatitis B, and smoking are major health issues within the Asian immigrant community.

While health data on Asians and Pacific Islanders are very limited, some national data for their subgroups are available for measures of reproductive health. Data indicate that among Asians and Pacific Islanders generally, infant mortality and low birth weight are below the national averages, although the accuracy of the available infant mortality data has been questioned (HRSA, 1991). Helsel, Pettiti, and Kunstadter found that the mean birth weight among Hmong immigrants is lower than the mean for Whites, but that no significant difference in the frequency of underweight births is evident across the two groups (Hesel, Pettiti, and Kunstadter, 1992). They suggest that the difference may be attributable to the difference in the size of childbearing women. The Japanese and Chinese populations demonstrated the lowest rates for infant mortality and birth weight problems across the Asian subgroups for which data were reported. In addition, Chinese and Japanese women are the least likely of all women in the U.S. to have preterm births.

Notably, as of 1986 Asians and Pacific Islanders as a group exceeded other minority populations in the use of prenatal care during the first trimester, with 75.6% receiving care as opposed to 61.6% of Black mothers and 60.3% of Hispanic/Latinas. It is important to recognize that this finding may obscure very high utilization of prenatal care by the more well-established Japanese and Chinese subgroups, and lower utilization by other Asian groups. Available data also indicate that Asians and Pacific Islanders are over-represented in terms of medical school enrollment. In 1987-88, Asians and Pacific Islanders comprised 4.4% of total enrollment, and 10.9% of first year enrollment, in schools of osteopathic medicine (HRSA, 1990). Again, it is important to remember that a great deal of internal variation is masked by such statistics.

Hispanic/Latinos

According to the U.S. Census, there were approximately 22.4 million persons classified as “of Hispanic Origin” living in the United States in 1990. This represents about 9% of the total population, an increase from 6.4% in 1980. This broad and diverse group includes people from Mexico, Cuba, Puerto Rico, and the other countries in Central and South America, and the Caribbean. The great diversity which exists across this group is related to:

- Education level
- Socioeconomic level
- Immigration status (documented vs. undocumented)
- Age
- Length of time in the United States
- Degree to which they have adopted “Anglo” behavior

- Rural vs. urban residence
- Country of origin -- historical, economic, and political experiences there
(Randall-David, 1984: 55)

Orlando Taylor also identifies some general cultural and communicative behaviors of “Hispanic/Latino Americans.” For his view, see Appendix #7.

The fact that many Hispanic/Latino immigrants are undocumented can present an additional barrier to health care and other public services. These “illegal aliens” may feel it is in their best interest to avoid contact with public agencies.

Traditionally, health and religion are intertwined in Hispanic/Latino culture. Physical imbalances and supernatural forces, magic, evil spirits and emotional strains are believed to cause illness. No distinction is drawn between physical and emotional disorders. Folk healers represent an important aspect of health care in traditional Hispanic/Latino cultures. The Curandero, whose treatments are based primarily on prayer and artifacts, usually possess the charismatic quality needed to succeed in a spiritually-oriented role. Espiritas and Santeros also practice forms of religious healing. The Yerbero utilize herbal remedies (Randall-David, 1989; Bullough and Bullough, 1982; Murillo-Rohda, 1981; Scott, 1981; Foster, 1981). The role of the Partera, or midwife, who is always a woman, has influenced the attitudes of Mexican-American women, who may tend to think that reproduction and birthing should be private matters of concern only to women. Hispanic/Latinos who are recent immigrants or of lower socioeconomic status often “divide diseases into two categories, consulting a folk practitioner for traditional diseases but an Anglo physician for ‘Anglo diseases’ ”(Bullough and Bullough, 1982:82).

Current Status of the Hispanic/Latino Population

Hispanic/Latinos are the fastest growing minority population in the United States. Much of this growth is due to natural increase. As of 1990, over 70% of the Hispanic/Latino population was native born. Data from 1987 indicate that the rate of birth to mothers of Hispanic/Latina origin was 23.3 births per 1000 total population as compared to a national rate of 16.6 per 1000 population (HRSA, 1990). Approximately two-thirds of the Hispanic/Latino population are classified as Mexican-American. This group is concentrated in the southwest. Puerto Ricans are most concentrated in the east, primarily in New York, while most Cuban Americans are found in Florida.

Available data for 1987 indicate that infant mortality for Hispanic/Latino Americans was below the national average, and in fact below the rate reported for non-Hispanic Whites. The under-reporting of infant deaths may, however, have influenced the accuracy of these estimates. The percent of low birth weight infants in 1987 among Hispanic/Latinos matched the national rate (7.0 versus 6.9%), although the Puerto Rican rate was substantially higher (9.3%). As of 1986, Hispanic/Latina mothers were the least likely of any group to have received prenatal care in the first trimester (HRSA, 1991). “Hispanics experience perhaps the most varied set of health issues facing a single minority population... . The leading causes of death among Hispanic Americans document several differences between their health experience and that of the total population” (PHS, 1991:34). As a group, Hispanic/Latinos are less likely than white non-Hispanics to die from

heart disease or cancer, while they are more likely to die from injuries, homicide, liver disease, diabetes, and AIDS. Smoking, alcohol abuse, and drug abuse are identified as major health issues within the Hispanic/Latino population. As of 1987-1988, Hispanic/Latinos were under-represented in their share of medical school enrollment, as compared to their proportion of total population. Only 5.5% of first year enrollment, and 3.2% of total medical school enrollment, was classified as Hispanic/Latino in that year.

Other Groups

In addition to Asians, Pacific Islanders and Hispanic/Latinos, there are a host of other minority culture groups represented in the United States, including, among others, African Americans, Haitians, African Immigrants, and Native Americans. It is important, however, to reemphasize that these commonly utilized divisions are neither concrete nor complete. Within the broad cultural groups which are commonly discussed, many subcultures can be identified. The level of detail used to view culture has a direct influence on the specificity at which resulting generalizations can be applied to individuals.

Native Americans

Among Native Americans there are widely divergent cultural traditions and backgrounds, "encompassing numerous tribes and over 400 federally-recognized nations" (PHS, 1991:38). While the Federal government tracks health data for Native Americans who utilize the Indian Health Service program available in states with reservations, over 50% of the estimated 1.3 million Native Americans reside in urban areas. Overall, Native Americans are younger, poorer, and less educated than the U.S. population as a whole. Diseases such as cirrhosis and diabetes, as well as alcohol-related injuries, are the most prevalent health problems among Native Americans. Although there certainly is some level of commonality among Native Americans across tribal and socioeconomic variations, there has been some ambiguity in the determination of how "Native Americans" are defined. It has been estimated that as of 1982 one in every eight Americans had at least one Native American ancestor (Bullough and Bullough, 1982:92). The commonly utilized criteria for classifying Native Americans ignore large numbers of Mexican-Americans "who are in fact the more or less [*sic*] pure-blooded descendants of the pre-Spanish residents of that country." Similarly, many Native Americans "with black ancestors are classed as black by the government, even though they have more [Native American] ancestry than black" (Bullough and Bullough, 1982:93).

People of African Descent

All people of African decent are commonly lumped into the broad category of "African" or "Black" Americans. While most members of this group have a long-standing heritage in the United States, there has been significant Black immigration in recent years from the Caribbean, most notably Haiti, as well as from African nations. "Because of their shared African roots, many Black Americans -- whether U.S born, or foreign born -- share common beliefs, practices, attitudes and values" (Randall-David, 1989:48). These groups share a common heritage, and may share the effects of racial discrimination. They may also share the same disadvantaged economic status.

There are, however, many variations across these subgroups in terms of culture and related health care needs. Overall, Black Americans are likely to “live in central cities, in areas typified by poverty, poor schools, crowded housing, unemployment, exposure to a pervasive drug culture and periodic street violence, and generally high levels of stress” (PHS, 1991:32). Certainly, this represents a shared cultural background which may contribute to health status disparities. Black Americans are more likely than Whites to suffer from heart disease, cancer, stroke, diabetes, injuries, HIV infection, and a number of other health problems. Immigrant subgroups such as Haitians, however, may not match this overarching profile. Haitians are likely to be recent immigrants that typically come from poor, rural backgrounds. They often do not speak English, and have cultural, religious and folk medicine traditions which isolate them from the larger Black community (Randall-David, 1989:52-54; Scott, 1981:106-107). In addition, Haitian immigrants often have entered the United States illegally.

Refugees

Those who migrate from their country of origin to escape conditions which are perceived as unlivable or life-threatening because of war, extreme deprivation, or political oppression are often referred to as refugees. “In the late 1970s and 1980s the United States experienced one of the largest influx of refugees in its history” (Hunt, 1989:49). There were approximately one million legal refugees in the U.S. as of 1989 (Hunt, 1989:48). Many of these refugees left Vietnam and neighboring Southeast Asia following the end of the Vietnam War. There are many more undocumented refugees from Central and South America and the Caribbean.

Dennis Hunt has constructed an overview of the stresses which often accompany the immigrant experience. Prior to leaving their homeland, many refugees suffer imprisonment and torture, the death of family members, the loss and destruction of homes and villages, repeated relocation, loss of employment, and undernutrition. After escaping their countries, refugees are often in “poor physical condition and emotionally stressed”. Together with poor sanitary conditions and poor nutrition, this leaves refugees vulnerable to disease. After enduring long waits in refugee camps under deplorable conditions, newly-arrived refugees are often disappointed with the lives they find in the United States. Many refugees are forced to assume new, unfamiliar roles in American society. Children who more easily adapt language and culture may act as “culture brokers” for their parents. Adults and children may have to accept a reduction in social and economic status, and suffer the racial discrimination of insensitive Americans, often from those in “competing” minority groups (Hunt, 1989:51-53).

Refugees from Southeast Asia generally lived through a “hurried and dramatic” departure from their homeland (Richardson, 1990:11). Cook and Timberlake in their discussion of Vietnamese refugees maintain that “psychological, financial, and other anticipatory preparations for the massive losses and changes accompanying the flight were usually not possible... . Such drastic uprooting affected every level of their existence as individuals, as members of a family, and as Vietnamese” (Cook and Timberlake, 1989:87). While refugees from diverse backgrounds may carry this shared experience of dislocation and disorientation, Hunt notes that they differ markedly in “religion, education, class, political orientation, and urban and rural lifestyles.” As with all groups, this diversity “makes it difficult to develop... guidelines which will be effective with all

refugee clients'' (Hunt, 1989:58). However, Hunt also characterizes refugees as ''remarkably resilient.'' ''Those who made it to American shores are survivors and have enormous potential for growth and change'' (Hunt, 1989:62).

Refugees should be viewed as persons who are momentarily out of step with the dominant culture in their new homeland and not as persons who will be permanently dependent. To facilitate their efforts to cope and adapt and to provide them with the tools for achieving the long-range goal of self-sufficiency, refugees need culturally sensitive and culturally relevant health, mental health, educational and social services (Cook and Timberlake, 1989: 97).

Concluding Remarks

Both cultures and sub-cultures do not exist in a vacuum. They are always part of a particular context, which is made up of historical, geographical, economic, social, and political elements. This means that the culture of any group of people, at a particular point in time, is always influenced by many other factors. Thus it may not be possible to isolate 'pure' cultural beliefs and behaviors from the social and material background where they occur (Taylor, 1990:21).

Each of the many and diverse cultural communities throughout the United States, and each of the individuals within them, has a unique set of characteristics and needs. In addition to the importance of culturally-sensitive communication, treatment, and education, there are other factors which are beyond the scope of this brief review, but which are nonetheless, critical to improving the health care available to members of racial/ethnic minority groups. An increase in the number of health care professionals from minority cultures would facilitate improved service to their communities (Ginzburg, 1991; PMC, 1991). In addition, access to health care is diminished for large segments of ethnic minority populations who are educationally and economically disadvantaged. Efforts to improve the overall economic status of minority populations, both directly through educational and training programs, and indirectly through economic growth, will contribute to the improved health of these groups. Lastly, improvements in the overall efficiency and equity of the health care and health insurance systems in the United States will improve access to health care and the overall health status of persons from culturally diverse backgrounds.

SURVEY REPORT

Overview

Cultural and linguistic barriers to health care affect many among the growing racial/ethnic minority populations in the United States. Local health departments (LHDs) are positioned to perform a critical role in assuring that health care is accessible and responsive to culturally and linguistically diverse populations. In addition to providing a means for monitoring the varying needs of these diverse groups, LHDs are a primary source of health services for those within cultural and ethnic minorities who may also be economically disadvantaged. The effort to monitor the way in which cultural and economic issues in health care are addressed, and to increase an understanding of the populations involved, to overcome barriers to health care that exist, must begin with appropriate needs assessments and evaluation tools.

The United States Conference of Local Health Officers (USCLHO) conducted a survey of LHDs in the spring of 1992 as part of its ongoing effort to gauge the status of health department services which are focused on non-English speaking (NES) populations. The survey data were supplemented by follow-up telephone interviews with LHD officers and bilingual program directors from the responding LHDs. Demographic data from the 1990 U.S. Census, structured to match the geographic boundaries of the reporting organizations, were also used to augment the survey data. The information from these sources has been analyzed in order to provide an appraisal of the following issues as they relate to NES populations.

- Availability of Programs and Services
- Information Collection Policies and Capabilities
- Status of Needs Assessment Research
- Perceived Barriers to Service
- Mechanisms Utilized to Enhance Services
- Targeted Marketing Strategies
- Current and Planned Policies and Procedures
- Human Resource Policies and Problems
- Perception of Technical Assistance Needs
- Interagency Relationships

SUMMARY OF FINDINGS

- Roughly 30% of responding local health departments (LHDs) that provide any specific service also target that service to non-English speaking (NES) populations. LHDs in large communities with large NES populations are most likely to provide targeted services.
- While 28% of responding LHDs represent communities exceeding the national proportion of NES population, only 16% of responding LHDs have conducted a needs assessment for a specific NES population.
- Over 37% of responding LHDs which have not conducted a needs assessment said they were unable to conduct a study because of limited resources.
- The survey responses indicate that across the jurisdictions in the sample, health information is not commonly available by race/ethnicity for major NES groups. This holds true even for those cities that have the largest proportions of NES populations.
- While 53% of responding LHDs have existing policies and procedures to deal with clients who do not speak English, only 27% have long-range or strategic plans that include specific objectives targeting NES populations.
- Twenty-seven percent (27%) of the surveyed LHDs believe that NES populations are “taking full advantage of their services.”
- Twenty-four (24%) perceive that their services are not fully utilized.
- Forty-nine percent (49%) replied that they do not know if NES populations are getting full use of available services. LHDs that represent cities with smaller NES populations, and those that do not have NES policies and procedures, are most likely to lack information on the extent of service utilization by NES populations.
- The most utilized, and most successful mechanism cited by responding LHDs for targeting services to NES populations was “establishing referral networks with other providers.” Following this, those mechanisms related to cost, such as “no cost” services, and the “provision of services without insurance,” were regarded as most successful.
- Marketing strategies that utilize direct outreach to the target populations, such as “attending community activities” and “health fairs,” are used to a greater degree than conventional media advertising through TV, radio, and newspapers.
- Analysis of the survey suggests that responding LHDs providing bilingual and multilingual information hot lines are most likely to perceive their services as fully utilized by NES populations.

- Among the barriers to providing health care to NES clients, those most commonly perceived by responding LHDs are: insufficient funding; lack of awareness of available programs coupled with inadequate knowledge among client populations of good prevention practices; language difficulties and transportation problems. With the exception of transportation problems, these barriers are significantly more prominent among cities with over 500,000 residents.
- Fewer than 20% of responding LHDs indicated that they have a minority affairs office, a minority affairs working group, or a NES advisory group.
- Over 60% of responding LHDs said they have difficulty recruiting bilingual and bicultural staff. Large cities with large proportions of NES populations were most likely to report difficulties in recruitment. The greatest recruitment difficulties involved physicians, dentists, and occupational/physical therapists.
- Survey participants were asked to identify the most important assistance they could receive to enhance the provision of health services to NES populations. The most frequently offered responses were: assistance in the identification and recruitment of bilingual staff; information on the current patterns of utilization of health services by NES populations; and assistance on how to make programs and services more accessible and acceptable to NES clients.

I. PROFILE OF RESPONDING LHD POPULATIONS

The USCLHO Multilingual Health Assistance Project Survey was mailed to 566 LHDs nationwide. The targeted LHDs were selected on the basis of city size and racial/ethnic composition. 175 LHDs responded to the survey. A population profile for the jurisdictions comprising the sample of 161 responding LHDs was compared to the national population, based on 1990 census data, in an effort to identify demographic factors that might differentiate responding cities from the country as a whole. Figures 1.1 and 1.2 summarize some demographic issues relevant to the survey topic.

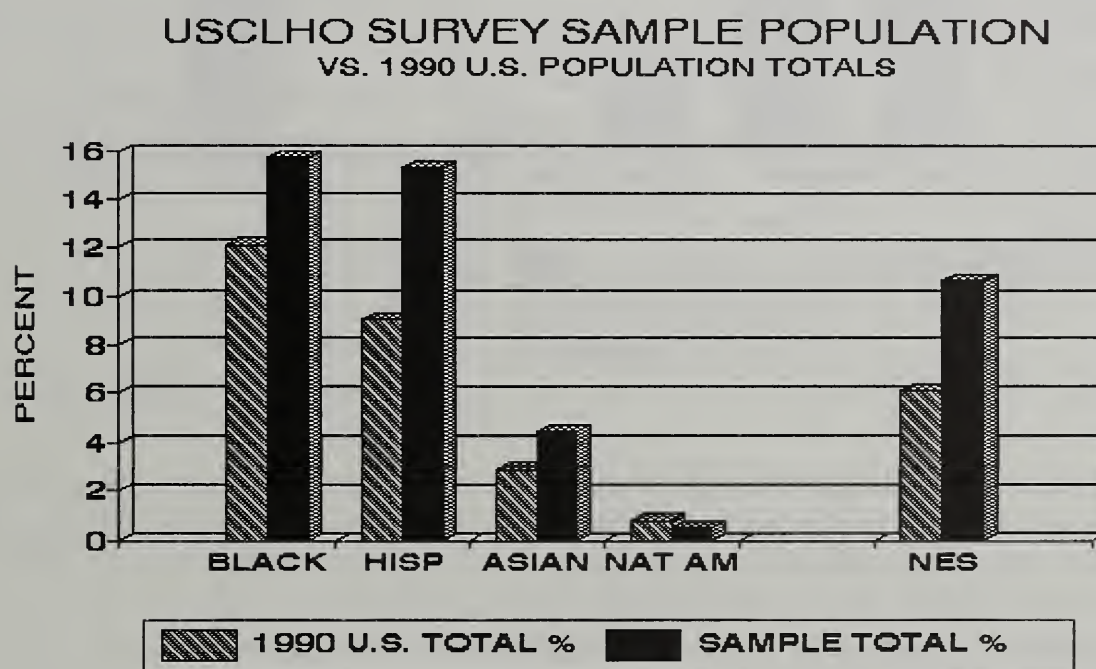


FIGURE 1.1

USCM/USCLHO 1992

LHDs in cities with larger minority populations were more inclined to answer the survey, as might be expected. The 1990 Census reports that 12.1% of the U.S. population is Black, as compared to 15.7% of the population represented by the sample. While 2.9% of the U.S. was identified as Asian or Pacific Islander by the Census, 4.4% of the total population of the sampled cities falls in this group. The Hispanic/Latino proportion in the sample is 15.3% as compared to 9% nationally, and the Native American sample of .5% is below the national total of .8%. Lastly, people over 5 years of age reporting that they “do not speak English very well” comprised 10.6% of the sample as compared to the national percentage of 6.1%.

USCLHO SURVEY SAMPLE MEAN PERCENTAGES VS. 1990 U.S. POPULATION PERCENTAGES

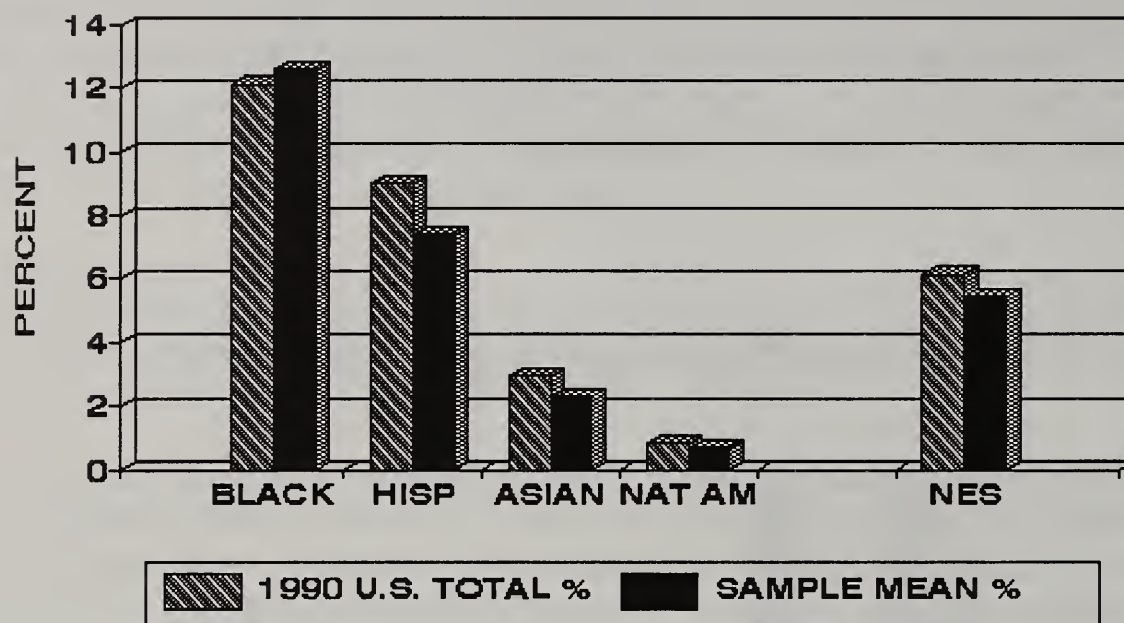


FIGURE 1.2

USCM/USCLHO 1992

Figure 1.2 compares the average percentage of each racial/ethnic composition across the surveyed city jurisdictions with the U.S. total percentages. This figure indicates that the sample LHD jurisdictions are reflective of overall national demographic patterns. It is important to note that 1990 Census data may not accurately reflect the undocumented immigrant and migrant populations. This comparison suggests that the average city in the sample closely mirrors, but falls slightly below, the “typical” U.S. city for categories associated with NES populations. The average percent of NES population across the LHD sample is 5.4% (ranging from .6 to 40%) as compared to 6.1% of the U.S. total population.

Responding LHDs were divided into five geographic regions as defined by the U.S. Census Bureau (Figure 1.3). While respondents are well distributed among the regions, the greatest number of surveys were returned from the South Atlantic and North Central areas.

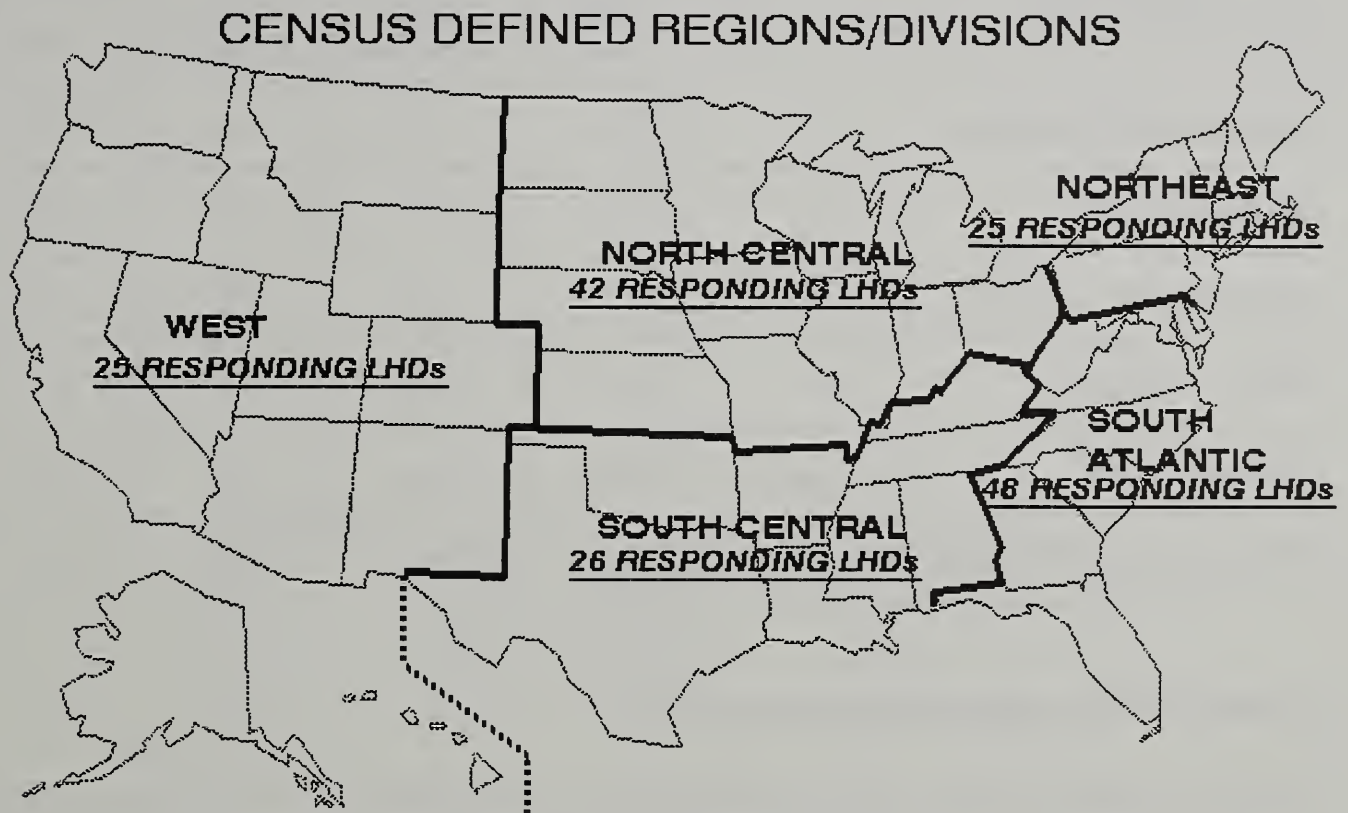


FIGURE 1.3

USCM/USCLHO 1992

Demographic profiles for the responding cities in each region largely follow expected patterns. Table 1.1 displays the average percentage NES population, the percentage of LHDs in each region with more than 5% NES population, the average percentage of major NES ethnic groups, and the average percent below poverty level. As would be expected, those LHDs in the West and South Central regions typically have higher concentrations of Hispanic/Latinos. The LHD jurisdictions in the West region have generally higher proportions of Asians and Pacific Islanders. The responding LHDs in the Northeast and West have the highest average percent NES. Over 50% of the surveyed LHDs in these two regions have greater than 5% NES population.

Table 1.1

**REGIONAL PROFILE OF RESPONDING LHDS
AVERAGE PERCENT**

Population Group	Northeast	South Atlantic	South Central	North Central	West
Non-English Speaking	7.3	3.6	6.7	2.7	9.5
Hispanic/Latino	6.2	3.9	15.7	2.2	16.9
Asian/Pacific Islander	2.4	1.7	1.3	1.8	5.4
Native American	0.3	0.2	0.6	0.5	2.3
Below Poverty	11.2	11.3	18.0	13.1	13.6
% LHDs with >5% NES	52.0	16.7	34.6	4.8	56.0

II. PROGRAMS ADMINISTERED BY LHDS

The survey asked responding LHDS to identify services administered by their departments, and then to identify those services which are “targeted” to NES populations. Table 2.1 summarizes the responses to this question for selected services.

Generally, less than 40% of LHDS offering a given service also target that service to their NES populations. Several service categories are available at particularly low overall and targeted levels. These are geriatric services, HIV/AIDS support services, and also the substance abuse, alcohol treatment, and mental health service categories. While some of these services may be available through other avenues, the minimal provision of linguistically and culturally oriented services in these categories may present a significant barrier to NES populations.

The responses relating to programs offered and targeted were compared by size of total population and by the percent NES population. Larger cities were more likely to provide services in both categories. Similarly, those jurisdictions with higher percentages of NES populations were more likely to provide language-targeted services. In general, responding LHDS serving big cities with large NES populations are most likely to provide targeted services. Smaller cities with small NES percentages are least likely to provide special services for NES populations.

Table 2.1

LHD SERVICES AVAILABILITY

SERVICE CATEGORY	% OFFERING SERVICES	% TARGETING SERVICES
AGE RELATED SERVICES		
Perinatal	76%	29%
Child Health	86%	34%
Geriatric	52%	14%
TB SERVICES		
Counseling	87%	37%
Treatment	83%	35%
Screening	90%	37%
HIV/AIDS SERVICES		
Counseling/Testing	85%	32%
Referral Services	77%	25%
Support Services	42%	15%
STD SERVICES		
Counseling	85%	29%
Treatment	83%	27%
Screening	81%	26%
OTHER SERVICES		
Immunizations	92%	36%
Family Planning	71%	26%
Health Education	87%	31%
Substance Abuse	15%	7%
Alcohol Treatment	11%	4%
Mental Health	14%	5%

Note: The percentages for the data as presented in this table were computed from the total sample of 175 so that the levels within each health category might be readily compared

III. NEEDS ASSESSMENTS OF NON-ENGLISH SPEAKING POPULATIONS

While over 28% of responding LHDs have populations exceeding the national rate of 6.1% for NES populations, just 16% of the 158 responding LHDs reported that they had conducted a needs assessment for a specific NES population. Eighteen (18%) of the 44 LHDs with NES populations in excess of 5%, and 21% of the 38 LHDs with populations greater than 500,000 had conducted needs assessments (See figures 3.1 and 3.2). Overall, smaller cities with low NES percentages were least likely to have conducted an NES population needs assessment.

NEEDS ASSESSMENT BY
PERCENT NES

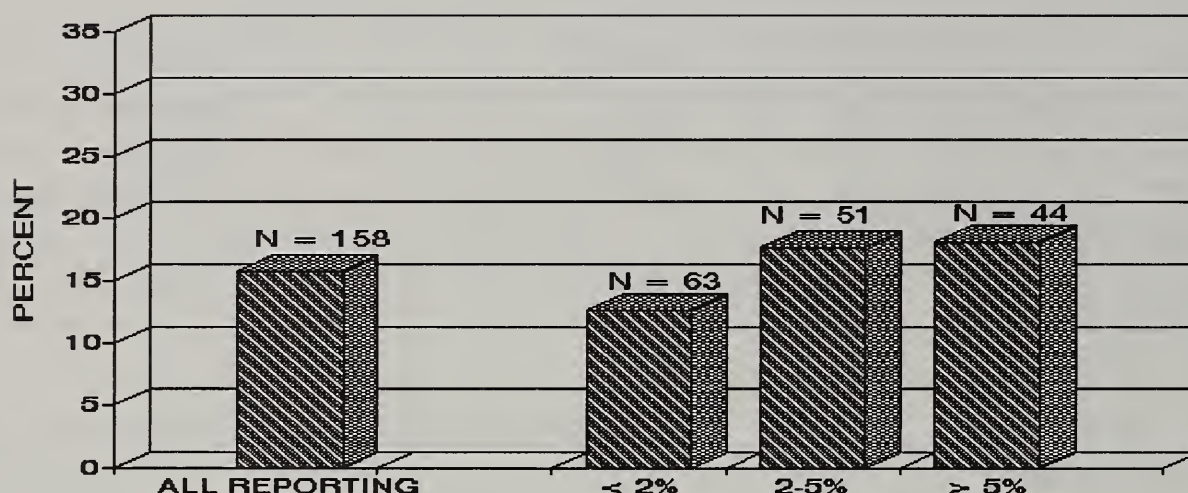


FIGURE 3.1

USCM/USCLHO 1992

NEEDS ASSESSMENT BY
POPULATION SIZE

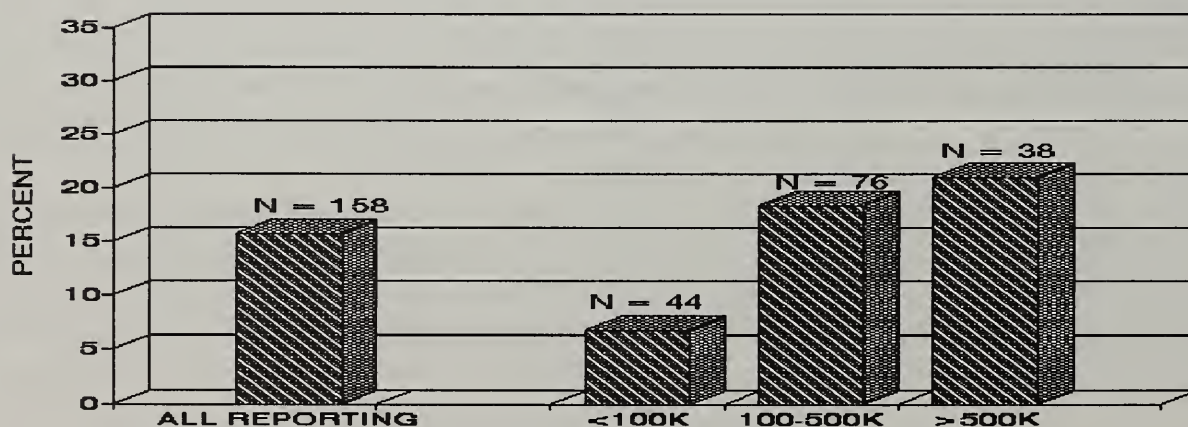


FIGURE 3.2

USCM/USCLHO 1992

LHDs with the largest Asian and Pacific Islander populations were most likely to have conducted an NES needs assessment. Thirty-one (31%) of those LHDs with Asian and Pacific Islander populations exceeding the average proportion for all responding LHDs (2.3%) indicated that a recent NES needs assessment had been completed (see Figure 3.3).

Note that while major centers of Native American populations at 8% fell far below the overall rate of 16%, those cities with the largest Hispanic/Latino populations matched the overall 16% rate for needs assessments. This finding also indicates that Asians and Pacific Islanders present a high profile, perhaps because larger cultural variations are perceived, or because of the attention which has been focused on Southeast Asian refugees.

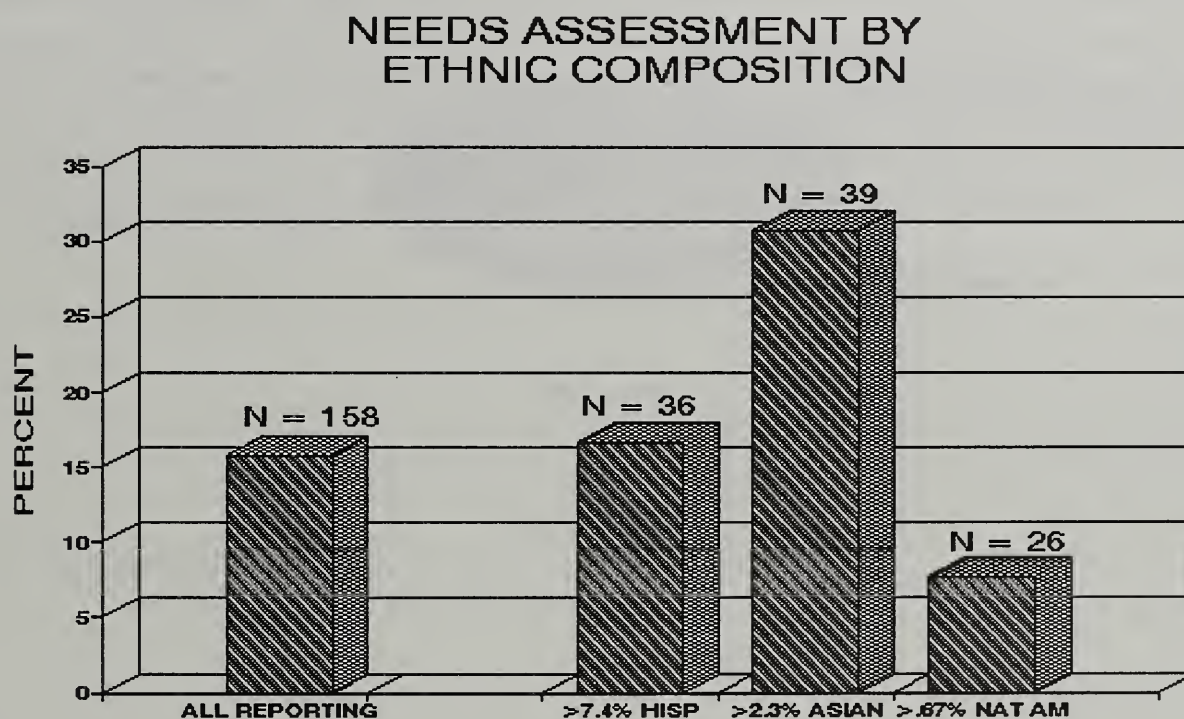
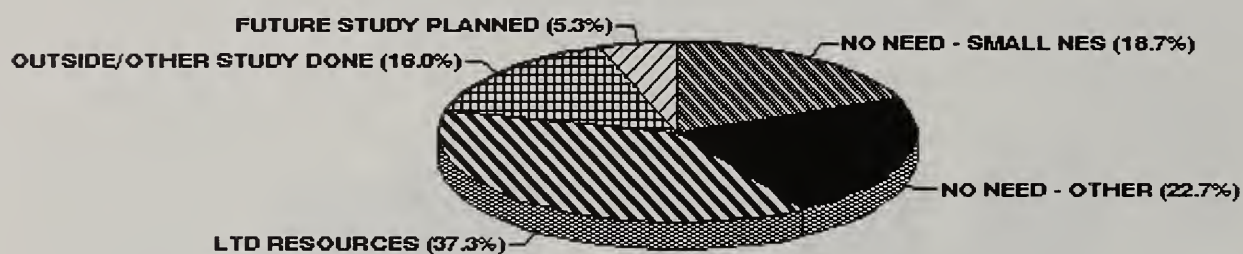


FIGURE 3.3

USCM/USCLHO 1992

The survey asked LHDs why they had or had not conducted a NES needs assessment. Figure 3.4 summarizes the responses of LHDs that said they had not conducted a needs assessment. While 6.3% reported that a future study is planned, over 37% said they were unable to conduct a study because of limited resources.

WHY NES NEEDS ASSESSMENT HAS NOT BEEN CONDUCTED



N = 75

FIGURE 3.4

USCM/USCLHO 1992

IV. HEALTH INFORMATION AVAILABLE BY RACIAL/ETHNIC CATEGORIES

Responding LHDs were asked if health information for racial/ethnic categories is available for their service areas. They were asked to identify the information available for their total service areas, and for each of six racial groups, by disease/mortality category. Table 4.1 displays the results. Generally, across all categories, information for “African Americans” was reported available by roughly 50% of those LHDs that reported they have data available. Data availability for other groups lags significantly behind this rate.

In order to gauge the influence of racial/ethnic group size on reported information availability for racial/ethnic categories, the responses for selected disease categories were broken down by the population percentages of selected racial/ethnic groups (Table 4.2). Responding LHDs were divided on the basis of their percentage of Black, Asian and Pacific Islander, Hispanic/Latino, and Native American populations. Those LHDs with the larger service area percentages of a given population were more likely to report that they have health information available for that population group. However, even those LHDs with the largest proportions of a given ethnic group are much less likely to have health information available for that group than they are for their overall populations, with the exception of information on African Americans in LHDs with the largest percentage of Blacks. The lack of information is most pronounced for the Asian and Pacific Islander group.

TABLE 4.1
INFORMATION COLLECTED BY RACE/ETHNICITY

LEGEND

AFRICAN AMER = African American
 AFRICAN IMMIG = African Immigrant
 ASIAN PAC ISL = Asian and Pacific Islander
 HAITIAN CARIB = Haitian/Caribbean
 HISP LAT = Hispanic/Latino
 NATIVE AM AK = Native and Alaskan American

CATEGORY	SERVICE AREA	AFRICAN AMER	AFRICAN IMMIG	ASIAN PAC ISL	HAITIAN CARIB	HISP LAT	NATIVE AM AK
N = 161	%	%	%	%	%	%	%
ADOL. PREGNANCY	85	57	11	27	12	36	29
CHILD MORTALITY	83	56	11	28	12	34	28
CHRONIC LIVER DIS	63	40	9	21	9	24	19
INFANT MORTALITY	87	60	11	29	13	37	27
LOW BIRTH WT.	84	59	11	27	11	37	26
MATERNAL MORTALITY	77	52	10	26	10	34	25
NEONATAL MORTALITY	83	57	9	26	11	34	26
POSTNEONATAL MORT.	79	53	10	26	11	33	25
RESPIRATORY COND.	65	40	8	20	9	26	20
VERY LOW BIRTH WT	81	55	10	26	11	34	25
CIRRHOSIS	63	40	8	19	8	20	17
OVERALL MORTALITY	79	53	9	24	11	31	23
BREAST CANCER	54	27	6	11	6	18	12
DIABETES	41	24	5	9	5	16	11
GONORRHEA	81	42	9	23	11	30	23
HIV/AIDS	87	53	9	29	12	40	26
HYPERTENSION	36	20	4	8	4	19	9
IMMUNIZATIONS	74	30	9	16	9	22	16
MALIGNANT NEOPLASMS	52	26	6	12	6	16	13
SMOKING/PREG	37	20	5	11	4	15	12
SYPHILIS	85	46	10	26	11	32	26
TB	88	46	12	29	13	34	28
UNINTENT INJURY	42	22	5	9	4	12	9
INTENT INJURY	54	29	6	12	5	17	12
VIRAL HEP. TYPE A	83	39	9	26	10	29	24
VIRAL HEP. TYPE B	84	38	10	26	10	28	24

TABLE 4.2

ETHNIC INFORMATION AVAILABLE BY ETHNIC COMMUNITY %	SERVICE AREA	AFRICAN AMERICAN		ASIAN/PAC. ISLANDER		HISPANIC LATINO		NATIVE AMERICAN	
		>12.6%	<12.6%	>2.3%	<2.3%	>7.4%	<7.4%	>0.67%	<0.67%
	N=161	N=52	N=109	N=43	N=118	N=37	N=124	N=25	N=136
CATEGORY	%	%	%	%	%	%	%	%	%
ADOL. PREGNANCY	85	83	45	40	22	59	29	60	23
CHILD MORTALITY	83	83	43	40	24	59	27	64	21
INFANT MORTALITY	87	85	49	40	25	62	30	60	21
LOW BIRTH WT.	84	81	49	37	24	59	30	60	21
RESPIRATORY COND.	65	67	28	30	16	47	19	40	16
CIRRHOSIS	63	65	29	28	16	32	16	36	14
BREAST CANCER	54	46	18	21	8	22	17	32	9
DIABETES	41	40	16	14	8	22	15	28	8
GONORRHEA	81	67	30	47	15	59	21	52	18
HIV/AIDS	87	77	42	44	23	68	31	56	21
HYPERTENSION	36	33	14	9	8	8	13	20	7
IMMUNIZATIONS	74	58	17	19	15	43	16	32	13
MALIGNANT NEOPLASMS	52	40	19	21	8	19	15	32	10
SYPHILIS	85	71	34	51	17	57	25	56	21
TB	88	73	33	47	22	62	23	56	23
UNINTENT INJURY	42	37	15	16	7	16	11	20	7
INTENT INJURY	54	48	19	26	8	30	13	28	10
VIRAL HEP. TYPE B	84	52	31	44	19	51	22	48	20

V. INSURANCE TRACKING

Only 6% of responding LHDs indicated that they track insurance information by racial/ethnic background.

Responding LHDs were asked why insurance data are or are not tracked by race/ethnicity. Of the 94 LHDs answering this question which do not track insurance by race, 36% said that it is not feasible to collect this information; 30% responded that such data are not needed because service is not provided on the basis of ability to pay; and 20% stated that they do not have the resources available to track this information (Figure 5.1).

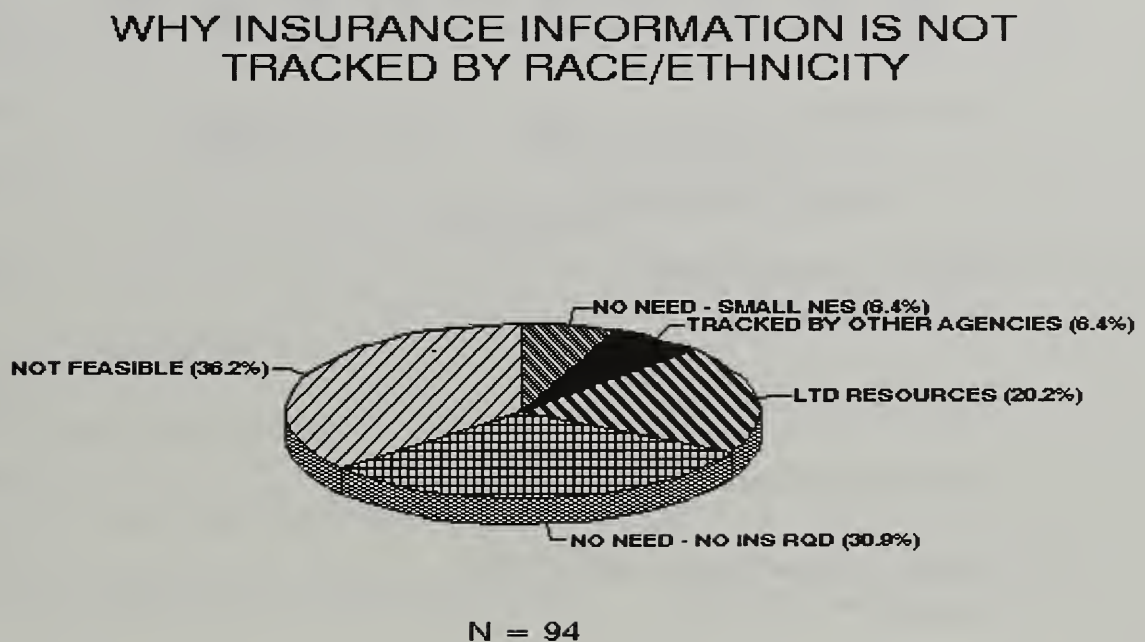


FIGURE 5.1

USCM/USCLHO 1992

VI. PROVIDERS AVAILABLE

Responding LHDs were asked to identify the kinds of health care services/providers available in their service areas. Table 6.1 presents the percentages of the 155 LHDs answering that have services available in the listed provider categories.

Table 6.1

SERVICE PROVIDER	PERCENT
1. Community-based organizations providing health services	70%
2. Uncompensated, emergency admission-based hosp. services	63%
3. School Health	54%
4. City or County Public Hospitals	49%
5. Community Health Centers (Federal section 330)	49%
6. Health Care for Homeless	46%
7. Public Housing-based services	29%
8. Federally qualified health centers FQHC (not sections 329, 330)	23%
9. Migrant Health Centers (section 329)	18%
10. Other	39%

All service providers with the exception of “Community-based organizations providing health services” are more likely to be available in cities where NES groups represent more than 5% of the population (Figure 6.1). The responses to this question were also analyzed by size of city. Responses from LHDs indicate that all of the above service provider categories were more likely to be present in jurisdictions of more than 500,000 total population.

SERVICES/PROVIDERS AVAILABLE FOR NES POPULATION OVER 5%

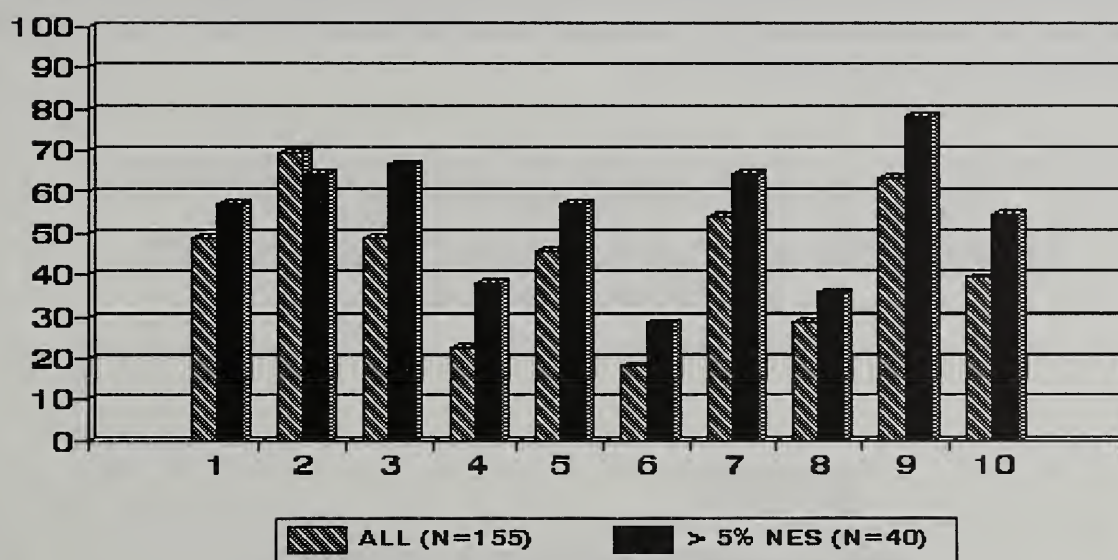


FIGURE 6.1

USCM/USCLHO 1992

SERVICE PROVIDER

1. City or County Public Hospital
2. Community-based organizations providing health services
3. Community Health Centers (federal section 330)
4. Federally qualified health centers FQHC (not sections 329, 330)
5. Health Care for Homeless
6. Migrant health centers (section 329)
7. School Health
8. Public Housing-based services
9. Uncompensated, emergency admission-based hospital services
10. Other

VII. SERVICE UTILIZATION BY NES POPULATIONS

The survey asked responding LHDs if “non-English speaking clients are taking full advantage” of their services. Overall, 27% stated that NES clients are taking full advantage of services, while 24% said they are not. Forty-nine percent (49%) responded that they did not know how well their services are being utilized by NES clients (Figure 7.1).

PERCEPTION OF FULL USE OF SERVICES BY NES CLIENTS

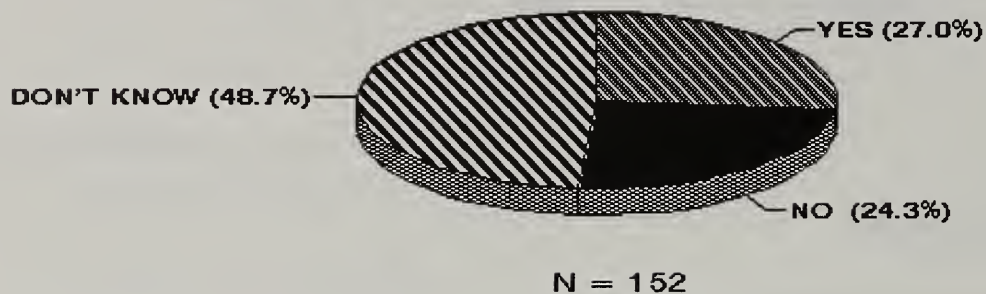


FIGURE 7.1

USCM/USCLHO 1992

Figure 7.2 outlines the perceptions of LHDs with regard to NES service utilization, broken down by their proportions of NES populations. Over 50% of those LHDs representing cities with populations less than 2% NES answered “don’t know” when asked if NES populations are making full use of their services. LHDs with larger proportions of NES populations were more likely to have an understanding of NES service utilization.

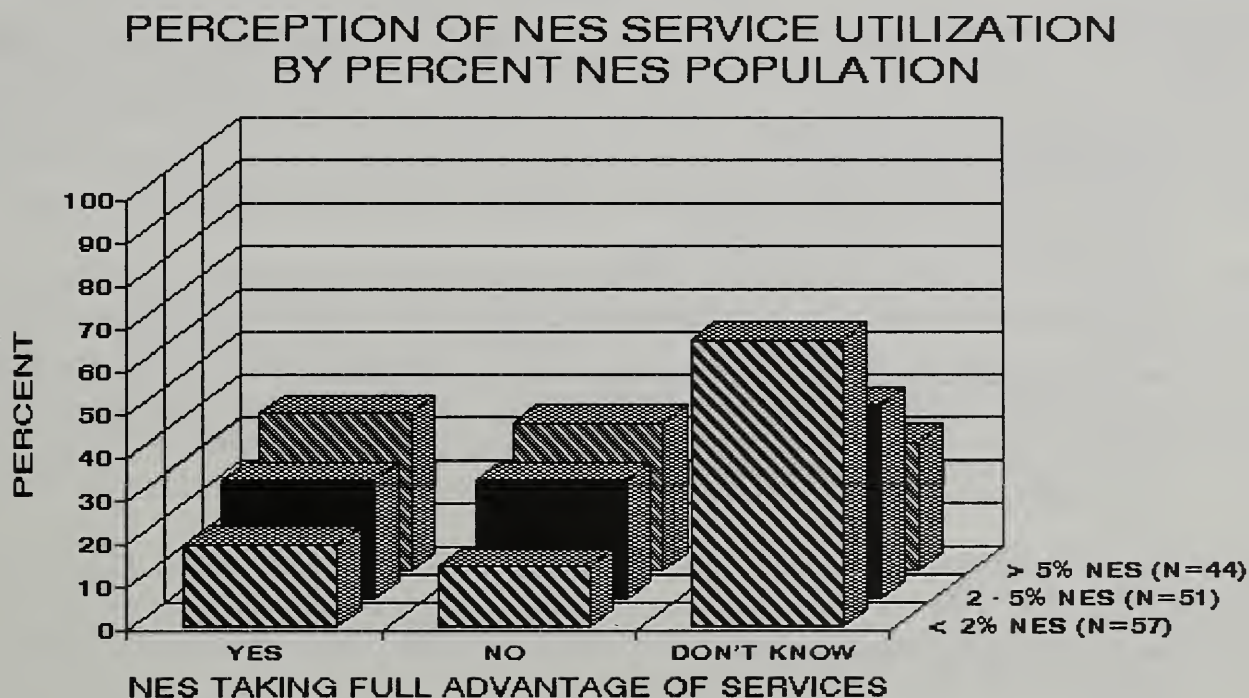


FIGURE 7.2

USCM/USCLHO 1992

VIII. SPECIAL PROGRAMS AND SERVICES FOR NES POPULATIONS

Responding LHDs identified targeting mechanisms used to enhance service to NES populations, and evaluated the level of success of each. Table 8.1 indicates the percent of responding LHDs which said they utilize each mechanism, and the percent of those that perceived the mechanism as "successful" or "very successful".

Table 8.1

TARGETING MECHANISM		%USING	% SUCCESSFUL/ VERY SUCCESSFUL
1.	Outreach efforts to educate/inform NES people of available programs (N=158)	66%	66%
2.	Health Education and Information targeted to behavioral, social, cultural and ethnic variables (N=140)	70%	59%
3.	Providing services in strategic geographic locations (N=138)	70%	65%
4.	Recruiting and retaining health care providers who are of diverse cultural backgrounds (N=134)	68%	46%
5.	Training health care professionals in the cross-cultural delivery of health services (N=133)	61%	47%
6.	Recruiting and retaining bilingual health care providers (N=132)	66%	52%
7.	Integrating neighborhood health workers as part of staff (N=131)	35%	35%
8.	Provision of services for clients without a source of health care insurance (N=136)	85%	69%
9.	Offering services at times and days of the week based on needs of clients (N=135)	73%	65%
10.	Offering transportation services to clients (N=135)	56%	51%
11.	Offering no-cost (free) services (N=141)	84%	68%
12.	Offering services on a sliding fee charge (N=137)	76%	65%
13.	Marketing/Media campaigns (N=133)	52%	65%
14.	Establishing referral networks with other providers (N=138)	89%	73%
15.	Establishing linkages with Medicaid eligibility workers (N=136)	76%	69%
16.	Facilitating the Medicaid eligibility process (N=135)	74%	66%

Figure 8.1 on page 46 compares the responding LHD perceptions of NES service utilization with the targeted mechanisms. In all but one category, those responding LHDs which implemented the identified mechanism were more likely to perceive their services as “fully utilized” by NES clients. Recruiting and retaining health care providers of diverse cultural backgrounds did not influence perceptions of full service utilization by NES populations across the sampled LHDs. Among responding LHDs not offering no-cost services, only 5% reported full utilization by NES clients as compared to 31% for those that do provide no-cost services.

Across all categories, the LHDs that do not utilize targeting mechanisms were more likely to be uncertain as to the full utilization of their services by NES populations. Generally, the majority of responding LHDs which are not using targeting mechanisms answered “don’t know” to the “full utilization” question. This suggests that those LHDs that have programs and policies with regard to NES populations may be more sensitive to the way their health department interacts with NES clients.

The most often used, and the most successful targeting mechanism cited was “establishing referral networks with other providers.” Following this, those targeting mechanisms that are related to costs, such as providing “no cost” services, the “provision of services without insurance,” and promoting Medicaid utilization, are most offered. Notably, “integrating neighborhood health workers as part of service staff” is used by only 35% of the 131 LHDs responding, and of those only 35% regarded the program as successful or very successful.

These responses were analyzed in terms of city population size and proportion of NES population. Generally, those cities with the largest populations, and those with the largest NES percentages are most likely to use the various targeting mechanisms. Similarly, those cities with the larger NES percentages were most likely to report that the mechanisms were successful.

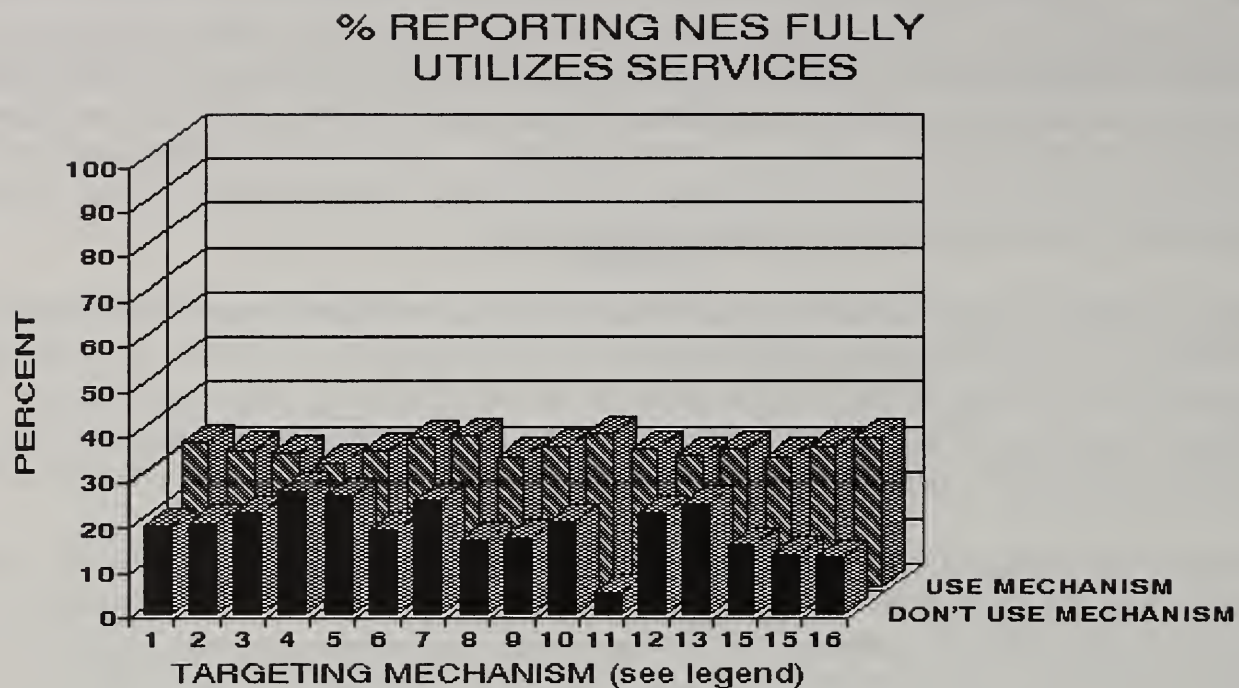


FIGURE 8.1

USCM/USCLHO 1992

TARGETING MECHANISM

1. Outreach efforts to educate/inform NES people of available programs
2. Health Education and Information targeted to behavioral, social, cultural and ethnic variables
3. Providing services in strategic geographic locations
4. Recruiting and retaining health care providers who are of diverse cultural backgrounds
5. Training health care professionals in the cross-cultural delivery of health services
6. Recruiting and retaining bilingual health care providers
7. Integrating neighborhood health workers as part of staff
8. Provision of services for clients without a source of health care insurance
9. Offering services at times and days of the week based on needs of clients
10. Offering transportation services to clients
11. Offering no-cost (free) services
12. Offering services on a sliding fee charge
13. Marketing/Media campaigns
14. Establishing referral networks with other providers
15. Establishing linkages with Medicaid eligibility workers
16. Facilitating the Medicaid eligibility process

IX. MARKETING TO NES POPULATIONS

Surveyed LHDs were asked if they “make specific efforts to market their services to those who do not speak English.” Of the 158 respondents answering this question, 49% indicated that they do make specific NES marketing efforts, while 48% indicated they do not, and 3% said they did not know.

The responses to this question were broken down by region. In the Northeast, 74% said they made specific NES marketing efforts. This compares to 68% in the West, 54% in the South Central Region, 43% in the South Atlantic, and 28% in the North Central Region. This mirrors the pattern of regional averages for NES populations noted earlier.

The survey asked those respondents that target marketing to NES populations to identify those specific marketing strategies used. Table 9.1 outlines the responses to this question.

Generally, the responses indicate that across the sampled LHDs, direct connections to the target population such as “attending community activities” and “health fairs” are utilized to a greater degree than conventional media advertising through TV, radio, and newspapers.

Table 9.1
NES MARKETING STRATEGIES

1. Attending community activities	81%
2. Health fairs	78%
3. Outreach to community leaders	77%
4. Language targeted flyers in neighborhoods	74%
5. Membership in community and professional organizations	62%
6. Radio	46%
7. Sponsorship of community events	44%
8. Ethnic foreign language newspapers	33%
9. TV	33%
10. Other	21%

Figure 9.1 illustrates that for the sampled LHDs, targeted marketing strategies are used more often in larger cities and by those LHDs with larger proportions of NES populations.

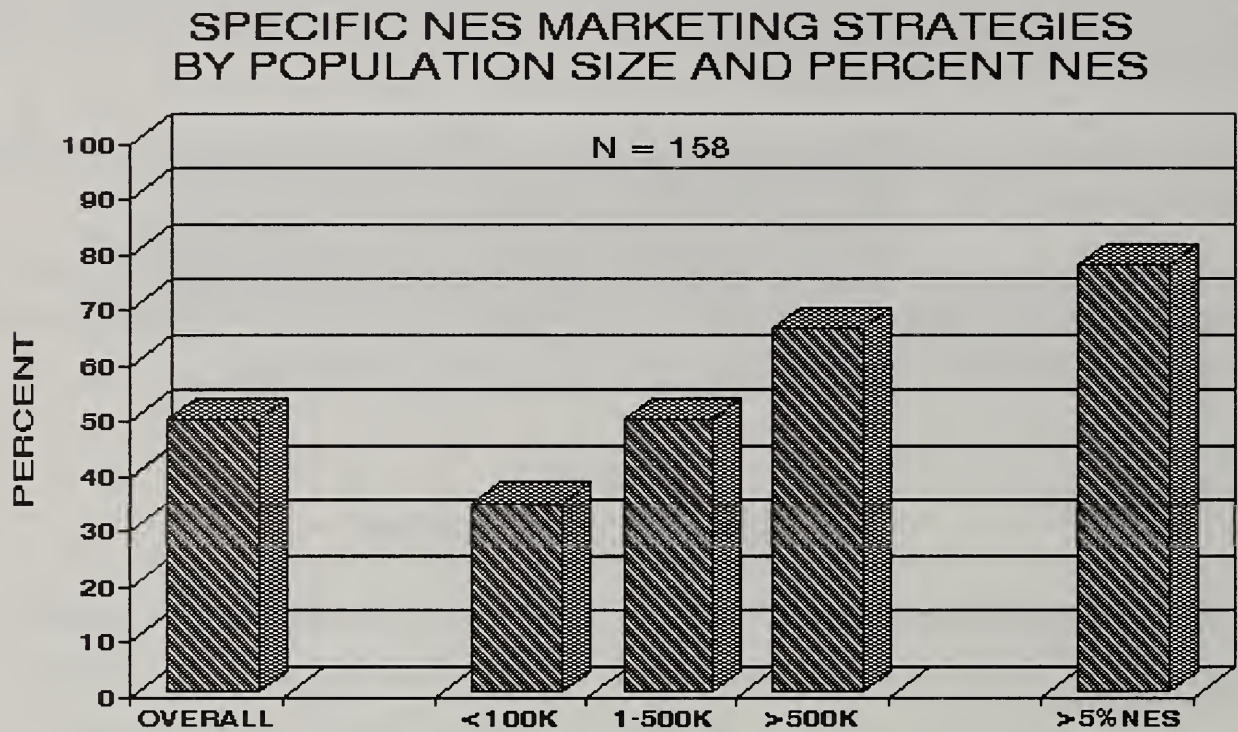


FIGURE 9.1

USCM/USCLHO 1992

Overall, those responding LHDs that utilize marketing strategies aimed at NES populations are more likely to have a perception of the success of their NES program. As with the targeting mechanism comparison above, LHDs that utilize NES marketing techniques were less likely than those that do not have NES marketing programs to answer “don’t know” when asked if NES populations are taking full advantage of their services (Figure 9.2). However, those responding LHDs that have NES marketing programs and answered either “yes” or “no” to the “full advantage of services” question most often responded that their services are not fully utilized. This may reflect heightened sensitivity to NES issues among these LHDs, or that they have larger NES populations creating higher levels of demand. This pattern holds true across the specific marketing strategies which have been identified.

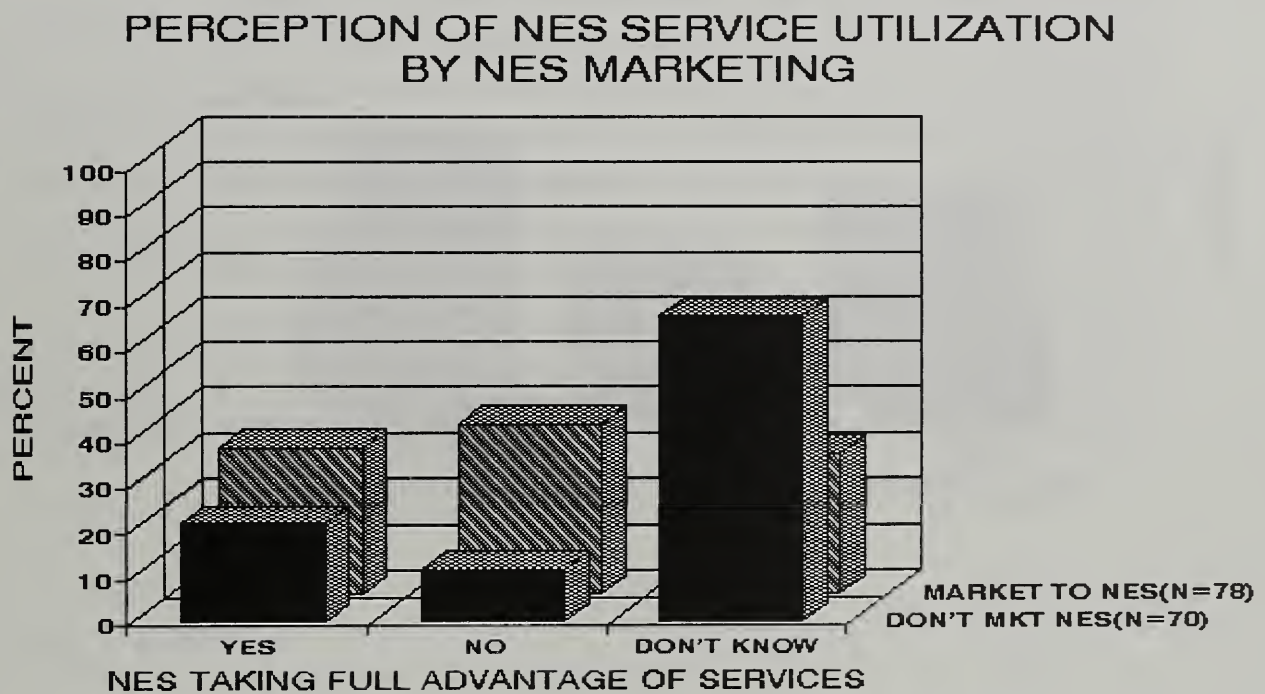


FIGURE 9.2

USCM/USCLHO 1992

Thirty-eight percent (38%) of responding LHDs said they use an “information hotline.” Of these, 24 or 40% said that their information line was “staffed in more than one language.”

In contrast to other marketing strategies, those LHDs reporting an information line staffed in more than one language most often perceived that their services are fully utilized by NES populations (Figure 9.3).

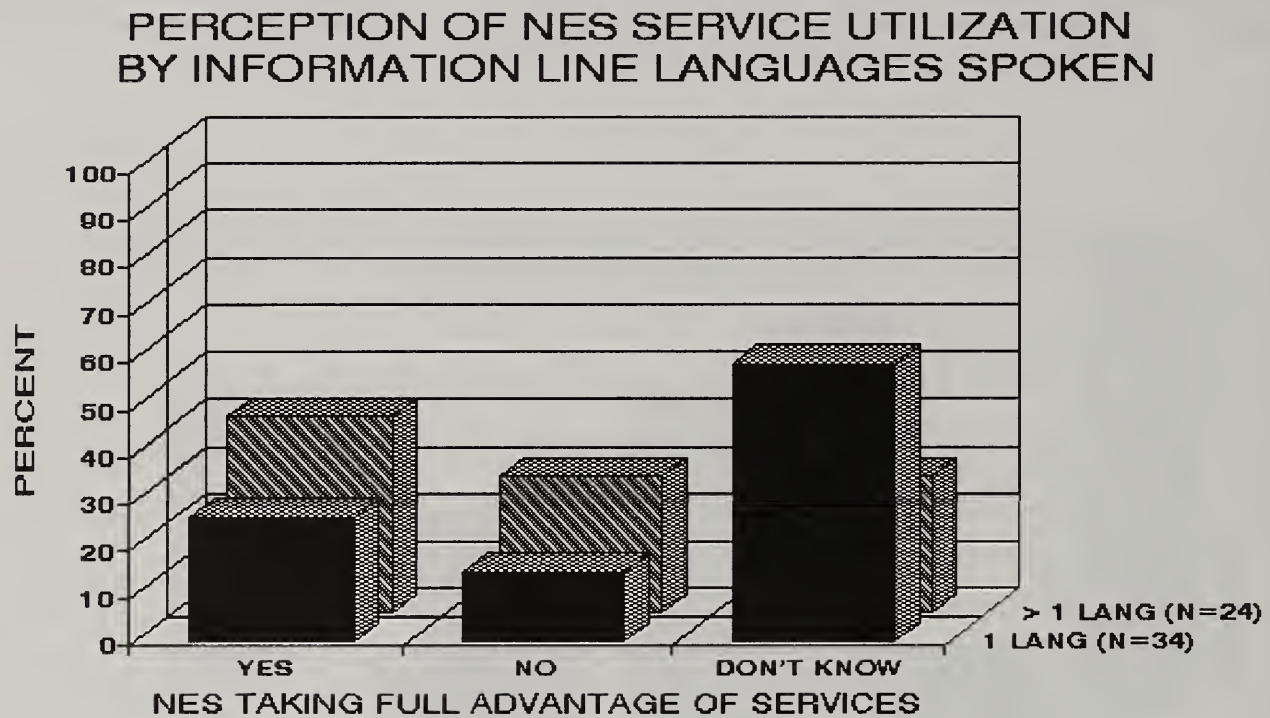


FIGURE 9.3

USCM/USCLHO 1992

X. PERCEIVED BARRIERS TO SERVICE

Those responding LHDs which did not believe NES populations were making full use of available services, were asked to identify why (Table 10.1).

Table 10.1

PERCEIVED BARRIERS TO NES SERVICE

1. Do not know about services or programs	64%
2. Do not understand prevention	64%
3. Transportation problems	60%
4. Language barriers exist	56%
5. Inadequate funding for programs and services	54%
6. Cultural barriers	33%
7. Scheduling hours are inconvenient	25%
8. They are not interested in our services	16%
9. Attitudes of health providers and staff towards clients	13%
10. Poor facility location	10%
11. Cannot pay for services/do not have health insurance	7%
12. Other	17%

The most commonly cited barriers across the responding LHDs were program awareness, prevention knowledge, transportation problems, language barriers, and program funding. Figure 10.1 illustrates the variation in perceived barriers for LHDs by city population size. All of the major barriers cited with the exception of transportation are significantly more prominent in cities with over 500,000 residents. In addition, cultural barriers were perceived more frequently for LHDs serving the largest and smallest cities in the sample. Figure 10.2 makes this same comparison by percent NES population. LHDs with populations in excess of 5% NES were more likely to note the “prevention understanding” and “scheduling barriers.” Cities with the largest and smallest NES proportions were more likely to cite funding as a problem than those in the middle range. This may indicate that cities with large NES percentages frequently experience budget shortfalls, and those with smaller percentages may find it difficult to justify requests for NES services.

PERCEIVED BARRIERS TO NES SERVICE BY LHD COMMUNITY POPULATION

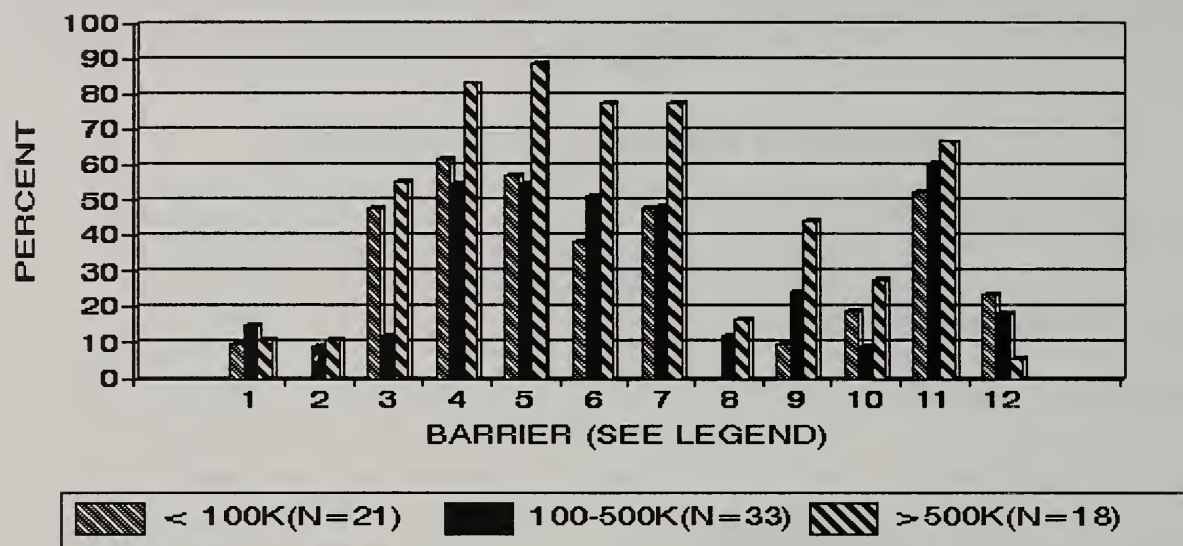


FIGURE 10.1

USCM/USCLHO 1992

PERCEIVED BARRIERS TO NES SERVICE

1. ATTITUDES OF HEALTH PROVIDERS AND STAFF TOWARDS CLIENTS
2. CANNOT PAY FOR SERVICES/DO NOT HAVE HEALTH INSURANCE
3. CULTURAL BARRIERS
4. DO NOT KNOW ABOUT SERVICES OR PROGRAMS
5. DO NOT UNDERSTAND PREVENTION
6. INADEQUATE FUNDING FOR PROGRAMS AND SERVICES
7. LANGUAGE BARRIERS EXIST
8. POOR FACILITY LOCATION
9. SCHEDULING HOURS ARE INCONVENIENT
10. THEY ARE NOT INTERESTED IN OUR SERVICES
11. TRANSPORTATION PROBLEMS
12. OTHER

PERCEIVED BARRIERS TO NES SERVICE BY LHD PERCENT NES

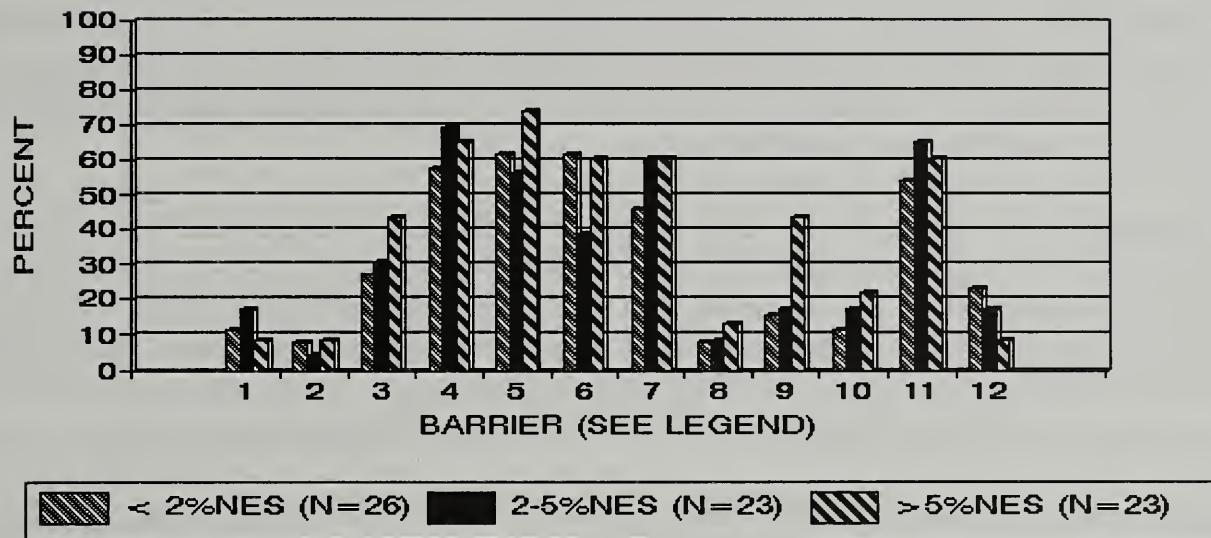


FIGURE 10.2

USCM/USCLHO 1992

PERCEIVED BARRIERS TO NES SERVICE

1. ATTITUDES OF HEALTH PROVIDERS AND STAFF TOWARDS CLIENTS
2. CANNOT PAY FOR SERVICES/DO NOT HAVE HEALTH INSURANCE
3. CULTURAL BARRIERS
4. DO NOT KNOW ABOUT SERVICES OR PROGRAMS
5. DO NOT UNDERSTAND PREVENTION
6. INADEQUATE FUNDING FOR PROGRAMS AND SERVICES
7. LANGUAGE BARRIERS EXIST
8. POOR FACILITY LOCATION
9. SCHEDULING HOURS ARE INCONVENIENT
10. THEY ARE NOT INTERESTED IN OUR SERVICES
11. TRANSPORTATION PROBLEMS
12. OTHER

XI. POLICIES AND PROCEDURES

Local health departments were asked if they have “existing policies and procedures to deal with clients who do not speak English.” Of 156 responding LHDs, 53% replied that they have NES policies and procedures, 43% said they do not, and 4% answered that they “don’t know.” Regionally, the West and South Central LHDs were most likely to have NES policies, exceeding the 53% aggregate at 61% and 67% respectively. Overall, those responding LHDs with populations between 100,000 and 500,000 were most likely to have NES policies.

LHDs were asked if they have “any annual, long-range plans, or strategic plans that have specific objectives for NES populations.” Of the 156 LHDs responding to this question, 27% indicated that they have such plans. Those LHDs representing cities with populations below 100,000, and those with NES populations below 2%, were most likely to answer in the affirmative. Those LHDs indicating they have long-range plans were asked if their plans outlined specific implementation actions. Of the 55 respondents answering this question, 62% said their plans did target specific actions.

The survey asked responding LHDs if they have any of the following three categories of formal organizational structure to deal specifically with NES or minority/ethnic issues. Less than 20% of responding LHDs indicated they have at least one. Table 11.1 summarizes the responses to these questions.

Table 11.1

NES/MINORITY AFFAIRS ORGANIZATIONAL STRUCTURE	%YES
1. Do you have a minority/ethnic affairs office or community staff liaison assigned at least 50% of the time?	16%
2. Do you have an internal minority/ethnic affairs working group?	15%
3. Do you have any non-English speaking advisory groups to your department?	19%

Those LHDs in the Northeast region were most likely to have NES advisory groups (33% of 18 respondents), whereas only 6% of the 32 responding LHDs in the North Central region indicated they have these groups.

The LHDs indicating they have NES advisory groups were asked to identify the ethnic groups represented. The 31 LHDs responding answered as follows (Table 11.2):

Table 11.2

RACIAL/ETHNIC GROUP	%YES
Hispanic/Latino	74%
African American	52%
Asian and Pacific Islander	48%
Native American/Alaskan Native	16%
Haitian/Caribbean Origin	13%
African Immigrant	13%
Arab American	10%
Mixed Racial/Ethnicity	25%
Other	25%

As might be expected, African Americans, Hispanics/Latinos, Asians and Pacific Islanders, and Native Americans are most frequently listed of those categories specifically defined.

XII. STAFFING/HUMAN RESOURCES PATTERNS PRACTICES

Respondents were asked if they find it difficult to recruit bilingual and bilingual/bicultural staff. For purposes of this question “bilingual” was defined as “persons who speak English and one or more other languages and who are not a member of that ethnic group.” “Bilingual/bicultural” refers to “persons who are both members of an ethnic community and speak the native language(s) of that community.”

Of 121 responding LHDs, 62% indicated that they have difficulty recruiting bilingual staff. A roughly equivalent percentage (61%) indicated that they have difficulty recruiting bilingual/bicultural staff. Contrary to the anticipated pattern, those LHDs representing the largest cities, and those with the largest proportions of NES populations, were more likely to report recruitment difficulty. Seventy-eight percent (78%) of those LHDs with populations over 500,000, and 74% of those with NES populations in excess of 5% reported difficulty in recruiting bilingual staff. Similarly, LHDs in the Northeast and West regions, with their high levels of NES populations, exceeded the national response rate to this question with 68% each. This differential may result from a greater inability to reach staffing goals in these communities, rather than from a variation in the availability of bilingual and bicultural health professionals in the employment base. Generally, larger jurisdictions with larger ethnic communities would be expected to contain larger numbers of racial/ethnic health care workers.

Appendix 1 identifies the “match” between languages spoken by LHD staff, and the languages that responding LHDs identified as spoken by their clients. The table does not reflect the relative size of the various NES communities, nor the number of staff that speak each language.

Recruitment Difficulty for Specific Employment Categories

The responding LHDs were asked to identify the degree of difficulty encountered in recruiting bilingual and/or bicultural staff in specific job categories. Table 12.1 outlines the percentage that described each category as “very difficult.” The surveyed LHDs indicated the greatest difficulty recruiting physicians, dentists, and occupational/physical therapists.

Table 12.1

RECRUITMENT DIFFICULTY

Category	Very Difficult to Recruit
Occupational/Physical Therapists	81%
Dentists	76%
Physicians	75%
Health Planners/Researchers	74%
Clinical Nurses	74%
Public Health Nurses	72%
Mental Health Therapists	71%
Administrators	64%
Nutritionists	60%
Health Educators	56%
Technicians/Technologists	51%
Social Workers	48%
Patient Advocates	36%

XIII. ASSISTANCE NEEDS/MECHANISMS FOR IMPROVEMENT OF LHD SERVICE TO NES POPULATIONS

Responding LHDs were asked to evaluate the importance of specific assistance needs and mechanisms that would improve their service to NES populations. Table 13.1 ranks the mechanisms on the basis of the percentage of respondents that perceived each mechanism as "very important." At least 40% of responding LHDs ranked all needs/mechanisms as "very important", with the exception of "supervision techniques to improve cultural competence" and "quality assurance/program evaluation." "Assistance in the identification and recruitment of bilingual staff" and "information on current patterns of utilization of health services of NES populations" were ranked by over 50% of responding LHDs as very important needs.

Table 13.1

ASSISTANCE NEEDS/MECHANISMS	VERY IMPORTANT
Assistance in the identification and recruitment of bilingual staff	53%
Information on current patterns of utilization of health services of non-English speakers	51%
Assistance on how to make programs and services more accessible and acceptable to NES clients	50%
Use of translators	48%
Information on the health status of NES persons	46%
Assistance in outreach/marketing efforts	42%
Inter-cultural communication training	40%
Assistance on how to make policies and programs more culturally sensitive/competent	40%
Supervision techniques to improve cultural competence	33%
Quality assurance/program evaluation	25%

XIV. INTERACTIONS AND LINKAGES WITH OTHER AGENCIES

Responding LHDs were asked to identify the types of formal linkages that exist between their departments and other organizations in the city, such as community health centers (CHCs), migrant health centers (MHCs), community-based organizations (CBOs), other non-profit organizations (ONPs), public schools (SCHs), or public housing projects (PHPs) (Table 14.1).

Case management linkages and patient/client service linkages are the most commonly cited linkage types utilized across all categories. Analysis of the relationship between fiscal linkages and other types of linkages for each organizational category suggests that fiscal linkages are mostly closely associated with personnel linkages, and planning/programming linkages within each organizational type.

Table 14.1

LINKAGES WITH OTHER AGENCIES

%LHDs REPORTING LINKAGES						
Linkages	CHCs%	MHCs%	CBOs%	ONPs%	SCHs%	PHPs%
Case Management	48	20	53	48	56	30
Fiscal	27	9	31	18	17	5
Homeless Health	30	12	28	28	13	12
Patient/Client	47	28	62	54	55	30
Personnel	28	15	31	22	31	13
Planning/Programming	30	17	43	38	45	17
Support Services	37	16	43	34	31	16
Other	4	4	4	4	4	1

LOCAL HEALTH DEPARTMENT CASE PROFILES

Overview

One of the main objectives of the Multilingual Health Assistance Project is to identify best practices in local health systems that address multilingual health care in urban areas. In an effort to disseminate information to local health departments (LHDs) on effective service responses to limited/non-English speakers, The United States Conference of Local Health Officers (USCLHO) has prepared case profiles of five types of geographically and culturally diverse LHD programs that offer specialized services to respond to the needs of limited/non-English speakers. Programs profiled are:

- Arlington County (VA) Department of Human Services: Home-based Nursing Services/Hispanic Outreach Program, Bilingual Dental Services, and HIV education outreach to non-English speakers -- programs primarily serving Hispanics and Southeast Asians;
- Boston Department of Health and Hospitals: Healthy Baby/Healthy Child Program, Interpreter Services, Midwife Training, Health Education Training Center, Hispanic Counselor Training Program, and the Mayor's Health Line -- programs primarily serving refugees from Southeast Asia and Eastern Europe, and new immigrants from Cape Verde, Haiti and Central and South America;
- New York City Department of Public Health: The Cross-Cultural Affairs Office's translation services, volunteer language bank and language sensitivity training -- programs serving perhaps the broadest spectrum of refugees, immigrants and non-English speakers (NES) in the nation;
- San Francisco Department of Public Health: Multilingual health services based in San Francisco General Hospital and other language service programs such as the Central American Patient Advocate program, the Bilingual Services program, cross-cultural training, and Multiethnic/Multicultural Psychiatric Services -- programs that primarily serve the Hispanic/Latino and Chinese/Cantonese communities; and,
- Three refugee health care programs: The International Health Clinic operated by the Multnomah County Health Department (Portland, OR); Seattle/King County Health Services Division's Refugee Screening and Medical Interpreter Services; and the Refugee Health Program, operated by the Chicago Department of Health.

The profiles reveal the unique steps each of the local health departments have taken to improve access to health services among linguistic minorities through outreach programs, interpreter services, translation of health education materials, patient advocacy, and cross-cultural training programs.

Each of the profiles contains summaries of the specific local program, client populations served, personnel and resource issues. In addition, the profiles conclude with a brief analysis of the lessons learned by the LHDs in developing and implementing their specialized programs for NES populations.

The case profiles are based on information gathered through analysis of documents and statistics provided by LHDs, the U.S. Census Bureau, and through telephone interviews with key LHD staff members. In some cases, information was gathered through on-site interviews with LHD officials. Final decisions on site selection were made in consultation with USCLHO's National Advisory Group, and staff from both the Office of Minority Health and the Health Resources and Services Administration.

ARLINGTON COUNTY DEPARTMENT OF HUMAN SERVICES

Health Director: Susan M. Allan, M.D., J.D., M.P.H
1800 NORTH EDISON STREET
ARLINGTON, VIRGINIA

(703) 358-4992

- **HOME-BASED NURSING SERVICES/HISPANIC OUTREACH PROGRAM**
- **BILINGUAL DENTAL SERVICES**
- **HIV EDUCATION OUTREACH TO NON-ENGLISH SPEAKING POPULATIONS**

SUMMARY

Many of Arlington County's linguistic minorities are recent immigrants, and may or may not be eligible for legal residence status. According to the 1990 Census, 20,512 persons (12% of total population) in Arlington County "do not speak English very well," and 11,895 (7% of total population) are considered to be below the poverty line.

In recognition of the fact that linguistic minorities need health services delivered in their own languages, Arlington County health officials have allocated resources to reach these special populations. The Arlington County Health Services Division (ACHSD), within the Department of Human Services, has responded to the needs of linguistic minorities through increases in bilingual staff and educational/service programs available to clients regardless of immigration status.

The Arlington County public health programs profiled are: Home-based Nursing Services/Hispanic Outreach Program, Bilingual Dental Services, and the HIV Education Outreach to Non-English Speakers.

BACKGROUND

Arlington County, located directly across the Potomac River from Washington, D.C., is an urban county of approximately 26 square miles. During the last three decades the Arlington County Department of Human Services has served distinct minority groups: African Americans, Southeast Asians, and, more recently, Hispanic/Latinos. There are other groups, such as Pakistanis, Afghans, and Ethiopians, that comprise a smaller percentage of service users.

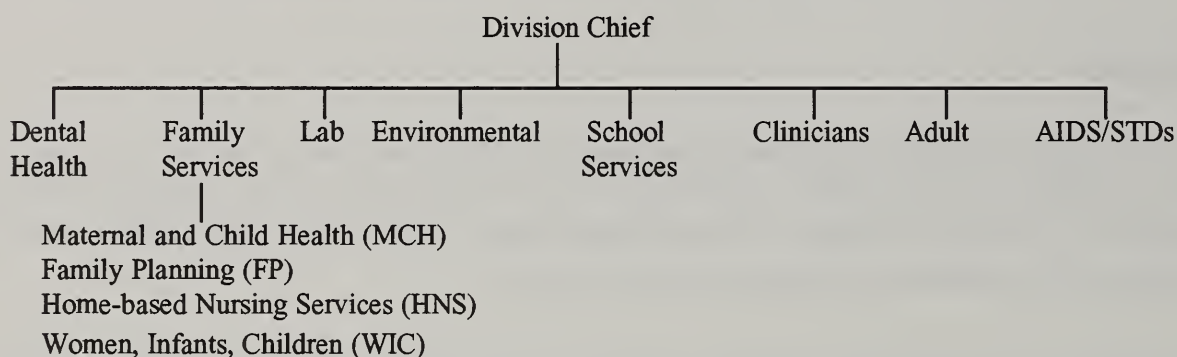
During the mid-1970's Arlington County received Federal funding to assist its growing refugee population from Southeast Asia. Due to their refugee status, many in this mostly NES population received a wide variety of health and social services specifically funded and tailored for refugees.

The current expansion of Spanish-speaking services began in the early 1980's when the Arlington County community saw a large influx of people from Central and South America who were seeking services from the ACHSD. Arlington County's Hispanic/Latino community grew 150 percent

between the 1980 and 1990 Census. In their countries of origin, many of the clients are from rural areas, have little or no education and commonly face problems of survival in an urban setting without language assistance and other social support systems.

Much of the initial impetus for increased health care access has come from the Hispanic Task Force which provided the local governing body, the Arlington County Board, with recommendations how to improve access to services, including health. Several community-based organizations (CBOs) have also forged linkages with the County structure, mainly for service referrals such as dental and prenatal care.

Arlington County Health Services Division



HOME-BASED NURSING SERVICES/HISPANIC OUTREACH SERVICES

The home-based nursing services/Hispanic Outreach Services (HNS/HO) program was created in 1986 due to a high number of young Hispanic/Latina women who delivered without prenatal care. Martha Derosiers, a Nursing Director who was interested in having services provided to the NES Hispanic/Latino populations, began the original program, known as the Hispanic Clinic, which led to the current services -- HNS/HO. Linkages with CBOs, such as Hogar Hispano and the Hispanic Committee of Arlington County, provided Arlington County government officials with information on where the Hispanic/Latino population lived. The "case-finding" method utilized in the outreach strategy by Hispanic Outreach was door-to-door in apartment complexes.

Structure

The Family Health Services Bureau (FHS) is one of eight Bureaus that constitute the ACHSD. The HNS/HO is one of four units within FHS. The other three units are Maternal and Child Health, Family Planning, and W.I.C. HNS/HO's objective is to provide home visits and/or clinic services for high risk infants, children and pregnant women through Spanish interpretation when needed. Public health nurses make home visits to assess needs and provide services for those with immediate risks, while outreach staff assess those who appear to be less at risk. Outreach staff ensure that follow-up appointments are made, attend to any immediate concerns, and provide feedback to public health nurses who determine the need for further nursing intervention. Transportation may be provided in special circumstances by the Fare Wheels Program.

Client Population

The client population served by FHS includes children up to the age of five, women of child-bearing age, and pregnant women. Client demographics indicate that in 1992 the largest number of Hispanic/Latino clients are from El Salvador (50-65%), the second largest group from Guatemala and Nicaragua, followed by Bolivia and Colombia and smaller groups from various other countries. Housing circumstances for this population commonly include multiple families in a single apartment supported by workers that hold 2-3 jobs to pay for food and housing. In these conditions, health care access becomes even more difficult.

Activities

HNS/HO provides comprehensive services for case management, periodic health assessments, screening, family planning, and prenatal care. The program has a full-time bilingual health educator who provides health education to clients in clinic waiting rooms, provides childbirth classes in Spanish, and coordinates a peer counseling program for women who are breast-feeding. Program presentations and health information delivery are conducted both on-site and in the field. There is one Spanish interpreter staff member available for services. Hispanic Outreach staff is also available to interpret for the different programs within the Family Services Bureau. In addition, there are one Vietnamese and two Laotian staff members who are available for interpretation if needed. Almost all educational materials and instructions are available in Spanish, with some in Vietnamese, Cambodian, Laotian, and other languages. All nutritionists are bilingual (Spanish/English).

Care Coordination is another service component of the HNS/HO program. Most of HNS/HO's referrals are from within ACHSD, but other County agencies within the Arlington County Department of Human Services (i.e., protective or social services) may send referrals that may require visits by HNS/HO staff. In addition, HNS/HO receives referrals from family members, friends, health care service professionals, case-findings and self-referrals. In Fiscal Year 1991, over 12,745 client contacts (home visits, consultative telephone calls, and office visits) were made by HNS/HO staff. Outreach staff conducted 536 home visits during the last six months of 1991.

Project Family, started in 1989, is an additional service resource housed at FHS. The League of United Latin American Citizens (LULAC Council #4606) encouraged Arlington County to implement Project Family, which was originally developed in Venezuela for low-income persons. Project Family's goal is to educate parents on safe and effective infant stimulation techniques to help prevent development and learning problems. Project Family includes prenatal education. Spanish-speaking volunteers and DHS staff conduct classes for parents throughout the year at the Fenwick Center and bilingual community centers operated through a partnership between Virginia Tech Extension Services and Arlington County Department of Human Services.

Personnel

The HNS/HO program operates with ten full-time public nurses and one full-time bilingual outreach worker. Two of the ten public health nurses are bilingual while four are learning Spanish.

New staff training consists of on-the-job training and two weeks of instruction covering public health concepts, medical terminology, as well as cross-cultural sensitivity. The Family Health Service's HNS/HO has extremely low staff turnover rates; most have been with the agency for at least five years, some for as long as ten.

BILINGUAL ADULT DENTAL PROGRAM

Structure

The Bilingual Adult Dental Program (BADP) operates within the Dental Health Bureau and provides dental services for low-income adults at the Arlington Department of Social Services Edison Complex located near two major bus lines.

Client Population

The BADP is targeted to low-income residents of Arlington County. The client population is mostly Hispanic/Latino. The rest of the client population consists of refugees, immigrants, and English-speaking American citizens.

Activities

The BADP provides primary dental care for adults not normally served by the County's dental care program, which targets financially disadvantaged children and senior citizens. The BADP operates two afternoons a week and provides basic dental care to clients that have been referred from Hogar Hispano, a CBO serving the local Hispanic/Latino community. Hogar Hispano advertises BADP services in its local newsletter and arranges appointments.

Personnel

The BADP currently contracts with a Spanish-speaking dentist for one afternoon a week but, due to high client demand, the dentist volunteers an extra afternoon of his time every week. Hogar Hispano provides a receptionist/clerk for the two afternoons of direct services.

HIV EDUCATION OUTREACH TO NON-ENGLISH SPEAKERS

Structure

This program operates out of the AIDS/STD Bureau within the ACHSD. Arlington County subcontracts with two CBOs -- Salud, Inc., and the Indochinese Community Center -- to provide HIV/AIDS outreach to Hispanic/Latino and Asian communities. Salud, Inc. primarily services Spanish-speaking persons, and the Indochinese Community Center primarily reaches Southeast Asian refugees and immigrants.

Client Population

While Salud's target population is mostly Hispanic/Latino, other minorities such as African Americans and African immigrants are also reached. Latina women in particular are targeted since they may be at risk and in sexual relationships with Hispanic/Latino gay/bisexual men. The outreach program provides Latina women the opportunity further to understand their own level of risk and what avenues of prevention they need to take.

Activities

In the Hispanic/Latino community, Salud's staff and its corps of volunteers under subcontract to ACHSD deliver HIV information at health fairs, recreation and sporting events, county health clinics, church socials, and community centers. ACHSD has collaborative agreements with the subcontractors in the areas of program delivery, training, and consultation on the educational activities of the project. The HIV/AIDS Bureau provides most of the technical information and testing related to HIV/AIDS, and the subcontractor provides direct linkages to the target population. This collaboration is significant and is a change in service delivery methodology for the Arlington County AIDS/STD Bureau. The Bureau recognizes that by subcontracting to minority CBOs it can incorporate culturally appropriate methods of program and information delivery. The same methodology is employed in reaching the Asian and Pacific Islander community through the Indochinese Community Center.

Personnel

CBOs provide the majority of staff and volunteers for HIV outreach to the NES communities of Arlington County. The AIDS/STDs Bureau has a staff of seven directed by the program manager (four staff are bilingual Spanish/English).

Resources

Funding for the outreach component is provided by the Virginia State Health Department through the Centers for Disease Control.

LESSONS LEARNED

The programs profiled above do not specifically target NES populations, but the percentage of NES within these programs ranges from 60-80 percent of the clients. There have been important outcomes, such as identification of and planning for target population needs, with community input before the implementation of a program.

LHD staff voiced concerns regarding the methods used to inform people about the ACHSD's programs. Many of Arlington County's NES that need services do not know the services exist. This is especially important in assessing the use of health services by minority groups such as Ethiopians and other African immigrants. Due to budgetary constraints ACHSD cannot conduct any further research in this area. A needs assessment might be the most efficient measuring tool, but that entails resources not currently available.

DEPARTMENT OF HEALTH AND HOSPITALS

Health Commissioner: Judith Kurland
818 HARRISON AVENUE
BOSTON, MASSACHUSETTS

(617) 534-5365

- **INTERPRETER SERVICES**
- **MIDWIFE TRAINING**
- **HEALTHY BABY/HEALTHY CHILD PROGRAM**
- **HEALTH EDUCATION TRAINING CENTER**
- **HISPANIC COUNSELOR TRAINING PROGRAM**
- **MAYOR'S HEALTH LINE**

SUMMARY

The City of Boston has allocated resources for training medical personnel to work with non-English speakers (NES). In order to improve access to health care among these special populations, the Boston Department of Health and Hospitals has increased bilingual staff, developed cross-cultural educational programs, and increased access to hospital-based interpretation service.

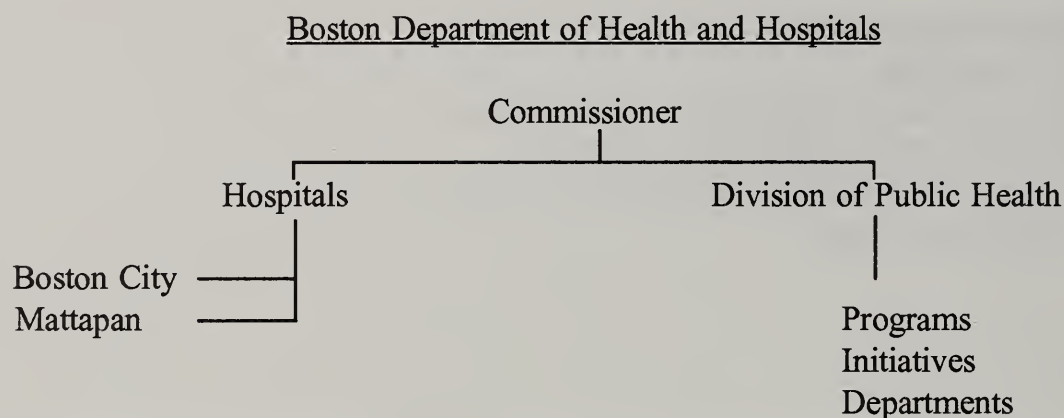
Boston's linguistic minorities are both recent immigrants and established residents. According to the 1990 Census, 69,590 persons (8.3% of total population) in Boston "do not speak English very well," and 102,092 (17.7% of total population) are considered to be below the poverty line.

The Boston Department of Health and Hospitals includes two principal sections: Hospitals, under which three hospitals are operated, and the Division of Public Health with various collaborative programs, community health centers and other neighborhood-based organizations. This case profile illustrates programs from each section. The programs profiled -- the Healthy Baby/Healthy Child Program, the Interpreter Services, the Midwifery Program, Health Education Training Center, the Hispanic Counselor Training Program, and the Mayor's Health Line -- are examples of how the City has attempted to remove language and cultural barriers to health care.

BACKGROUND

The Boston Department of Health and Hospitals serves a diverse population in the City. There are both established and recently-arrived minority groups utilizing local health services. Among these groups are African Americans, Irish Americans, refugees from Southeast Asia and Eastern Europe, and new immigrants from Cape Verde, Haiti, and Central and South America. There are an estimated 60,000 undocumented residents in Boston. Many among them do not seek health care due to the fears associated with their undocumented status in the United States.

Nearly 80 percent of Boston City Hospital's admissions come from its emergency room, and nearly half of those served by Boston City Hospital are uninsured. Half of those who receive inpatient and outpatient care are financed by private insurance, Medicare, or Medicaid. The Department of Health and Hospitals is funded by grants and contracts totaling more than \$45 million dollars. The Trustees Corporation, formed in 1965, coordinates and oversees the funding process. In 1984, Mayor Raymond L. Flynn established the Boston Committee on Access to Health Care to focus on health care access for low-income and uninsured people and families. The establishment of the Mayor's Health Line was the first initiative of the Committee to assist this population in obtaining health care services.



HEALTHY BABY/HEALTHY CHILD PROGRAM (HBHCP)

Structure

The HBHCP is operated by the Division of Public Health which is the City's Health Department. The Healthy Baby program was started in 1985 in response to alarming statistics that indicated a sharp increase in infant mortality and a growing gap between non-White and White infants. In 1989 the program was decentralized and located in neighborhood health centers. The Healthy Child component, created in 1987, is a post-delivery service program of the HBHCP and works in conjunction with the Healthy Baby program. The Healthy Baby and Healthy Child programs are examples of how outreach and service for high risk women and children were redesigned as community-based collaborations and relocated in community health centers.

Target Population

Most of the target population is low-income and is either uninsured or receives Medicaid. A high percentage of NES clients are from Cape Verde, the Dominican Republic, Haiti, and Puerto Rico.

Activities

The Healthy Baby program provides comprehensive prenatal care to women at high risk for low birth weight. The Healthy Child program provides extensive post-delivery follow-up for 6 months, with counseling activities based on an individualized service plan.

Both programs provide bilingual and bicultural communication and support through the trained bilingual/bicultural staff. There is a mechanism called the Help Line (staffed in Spanish, Haitian, and English) which is used as an outreach/follow-up for clients two-and-one-half years after delivery. This follow-up encourages clients to use other health care services that can be made available through the Mayor's Health Line.

Personnel

The 61 program staff members include nurses, social workers, and health advocates that speak the native languages and understand the cultural beliefs of the women involved. Approximately half are bilingual in the following languages: French-Creole, Haitian-Creole, Portuguese, Portuguese-Creole, and Spanish.

Resources

Funding is furnished by the Boston Department of Health and Hospitals. Additional resources are also provided through grants from various public and private sources.

HEALTH EDUCATION TRAINING CENTER (HETC)

Structure

The HETC is a collaborative training effort of the Boston Department of Health and Hospitals and the Boston Area Health Education Center. Under the charge of the Division of Public Health, the HETC's mission is to provide certified training in assorted public health issues to staff from various programs in the Department of Health and Hospitals.

Target Population

The people trained by HETC are on the staff of such programs as Healthy Baby/Healthy Child, Emergency Medical Services and Lead Poisoning. Most people served by HETC are health educators working in different areas of outreach.

Activities

The curriculum is divided into two areas -- core, and diversity training. The core training involves public health issues in general, and offers concentrations in areas such as substance abuse, violence, HIV/AIDS, perinatal health, urban adolescent health, and the development of health education materials. The diversity instruction covers cultural views and beliefs within various racial/ethnic populations. The diversity training does not entail interpretation skills or issues of language. The core training is two half-day long classes over three-and-one-half weeks. The diversity training is two half-day long classes over the span of three weeks.

Personnel

The current staff consists of a program coordinator and a receptionist. Training is conducted by staff members of the Department of Health and Hospitals.

Resources

Funding for the program comes from the Massachusetts Department of Medical Security and the Federal Health Resources and Services Administration.

HISPANIC COUNSELOR TRAINING PROGRAM

Structure

The Hispanic Counselor Training Program is operated by Addiction Services within the Division of Public Health. The program provides comprehensive clinical training for bilingual counselors from agencies across eastern Massachusetts. Both entry-level and advanced skilled clinicians serve Hispanic/Latinos with alcohol and drug problems.

Target Population

The target population includes Hispanic/Latino paraprofessionals and professionals in the State of Massachusetts.

Activities

Recruitment is conducted among substance abuse agencies as well as general health and social service staff. Training covers clinical components of substance abuse treatment issues.

Personnel

Training is conducted by Addiction Services staff and has so far selected and trained 16 people from various agencies in Massachusetts.

Resources

Resources are provided by the Boston Department of Health and Hospitals.

INTERPRETER SERVICES DEPARTMENT (ISD)

Structure

The ISD is operated by the Department of Health and Hospitals and is located at Boston City Hospital. The program primarily provides interpretation for both providers and clients at Boston City Hospital.

Additional requests may come from such programs as the Division of Public Health's Lead Poisoning Project. To carry out its purpose the ISD includes full-time and on-call staff.

Target Population

The target population consists of NES clients at Boston City Hospital.

Activities

The ISD provides interpretation for any interaction between patients and providers in the Boston City Hospital system. This service may entail admission procedures, social services, or nursing care. Through the combination of full-time and on-call staff there are interpreter services available 24 hours a day in Chinese, Creole, and Spanish.

Personnel

Most of the interpreters are trained foreign-born medical professionals (doctors and nurses) who are currently not certified to practice in the United States. There are four full-time Spanish interpreters, two full-time interpreters for Haitian, two full-time interpreters for Cape Verdian, (both Haitian and Cape Verdian languages also have part-time interpreters), one full-time interpreter for Vietnamese and Chinese, and a pool of on-call interpreters for evening and weekend shifts.

Each interpreter receives approximately 48 hours of individual training that includes medical affairs, interpreter skills, and cross-cultural issues.

Resources

Resources are provided by the Boston Department of Health and Hospitals.

NURSE MIDWIFERY PRE-CERTIFICATION

This program operates out of the Boston City Hospital. The target population consists of foreign-trained nurse/midwives. The program prepares these nurses to take an examination for midwife certification in the United States.

In exchange for this training many of the midwives work with populations from their own countries of origin. Certification is given by the University of Kentucky.

Resources

Resources are provided by the Massachusetts Department of Health. The project is scheduled to end in December, 1992.

MAYOR'S HEALTH LINE (MHL)

Structure

The MHL is operated by the Department of Health and Hospitals in conjunction with the Boston Committee on Access to Health Care (BCAHC). It is an initiative from the Office of the Mayor. BCAHC focuses on improving access to health care for low-income and uninsured individuals and families. There are working relationships with other programs such as Interpreter Services based at Boston City Hospital.

Target Population

The target population consists of low-income and uninsured residents of Boston.

Activities

The program provides multilingual information, referral, and advocacy to help the uninsured and disenfranchised take advantage of existing options for health care and public or private coverage. In 1990, the MHL served 215 NES, the majority (162) of them uninsured. Most of these clients used hospitals (51%) and health centers (38%) as their source of health care.

Personnel

The program has five staff members managed by a Director. Two are bilingual (English/Spanish) and other languages are handled by AT&T's foreign language conference call service.

Resources

Resources are provided by the Boston Department of Health and Hospitals, the Conference of Boston Teaching Hospitals, the Harvard Community Health Plan Foundation, the New England Telephone Company, the Bank of Boston, and the Massachusetts Department of Medical Security.

LESSONS LEARNED

In spite of all of the efforts by the Boston Department of Health and Hospitals to improve access to health care services for NES populations, there are still several needs that must be addressed, according to Boston public health officials. One such need is for an interdepartmental coordinating committee on health care for NES populations.

Another is for integration of the training conducted by Interpreter Services with the diversity instruction given by the Health Education Training Center. There is also a need for additional outreach in certain health programs, but funding for such work is currently not available.

NEW YORK CITY DEPARTMENT OF PUBLIC HEALTH

**Health Commissioner: Margaret A. Hamburg, M.D.
125 WORTH STREET
NEW YORK, N.Y. 10013**

(212) 788-5261

CROSS-CULTURAL AFFAIRS OFFICE

SUMMARY

According to the 1990 Census, 1,361,746 New York City residents (18.5% of total population) “do not speak English very well,” and 1,384,994 (18.9% of total population) were considered to be below the Federal poverty line.

The Cross-Cultural Affairs Office (CCAO) was established by the New York City Department of Health (NYCDH) in 1987 to provide emergency translation/interpretation services through a language bank, and to contribute technical assistance for health education activities and public health campaigns directed at the diverse non-English speaking (NES) populations of the city. CCAO’s main objective is to develop health education campaigns that focus on current public health issues: HIV/AIDS prevention, HIV/AIDS and women, TB, and lead poisoning. CCAO identifies language volunteers within the NYCHD for the volunteer language bank, and conducts training seminars in cross-cultural and health issues for volunteer interpreters and translators.

BACKGROUND

In October 1985, then-Mayor Edward Koch established a Commission on Hispanic Concerns to identify the significant problems confronting Hispanic/Latino residents. In the area of language, it was ascertained that of the 1.5 million Hispanic/Latino residents in New York City, 20 to 30 percent had limited-English speaking ability and that there were approximately 250,000 other limited-English speakers residing there. The Commission surveyed all City agencies and determined that language barriers restricted access to essential services for limited-English speakers. Mayor Koch created the Office of Language Services in September 1987 to ensure that each City agency could provide services to limited-English speakers.

The first translation of material was done in Spanish, since Hispanic/Latinos are the largest minority group in New York City. This presented challenges because there are several large subgroups within this population and each has its own cultural norms. According to the 1990 Census, the breakdown is as follows: 896,763 Puerto Ricans, 61,722 Mexicans, 56,041 Cubans and 768,985 other (Dominicans and Colombians are sizable groups in New York City). Materials have since been translated into other languages, such as Chinese, Creole, French, Korean, and Russian. These languages were included in the early stages of CCAO, and therefore had an impact on the development of health campaigns for measles, TB, and hepatitis B. NYCDH personnel training was organized to cover issues

that focused on outreach, development of language-sensitive materials, and the methodology needed to reach the target populations.

STRUCTURE

CCAO currently provides consultation and technical assistance to various divisions within the NYCDH that conduct public health campaigns in various languages. CCAO serves as the NYCDH's liaison to the Mayor's Office of Language Services. The New York City Language Services Task Force is comprised of representatives of many City agencies.

Originally CCAO was physically located within the NYCDH's Public Health Division. Currently CCAO is located within the NYCHD's Office of External Affairs, which coordinates media campaigns and other events in addition to public health education.

CLIENT POPULATION

The NES residents of New York City are the target population. Outreach methods the CCAO utilizes in its health campaigns are television, radio, newspapers, printed materials, subway trains and stations, buses and bus stops.

ACTIVITIES

Health Education Materials and Campaigns

CCAO translates educational materials into Spanish and contracts with private vendors for translation of health promotion materials in languages such as French, Creole, Chinese, Korean and Russian. In addition, CCAO conducts focus groups, field tests health materials, and develops materials for media health campaigns. CCAO networks with various community agencies, non-profits and minority organizations that deal with limited-English speakers.

For process and quality control in the development of culturally appropriate health education materials, CCAO formulates advisory groups from the target population, conducts focus groups that include the target population, reviews and translates materials for appropriate language usage, conducts field tests of completed materials, and revises the final product to assure continued cultural appropriateness.

Since 1990 one of the most successful media campaigns ("La Decision") focuses on AIDS. The campaign addresses the issue of condom usage by a young female's partner, marketing the message through public service announcements, comic books, and posters. Program evaluations to determine the precise effectiveness of media campaigns developed by CCAO have not been undertaken due to the lack of resources. The current method of assessment simply tracks the increased number of hotline calls and letters received by NYCDH.

Volunteer Language Bank

CCAO administers NYCDH's volunteer language bank. Language banks exist in all City agencies and are coordinated by the Office of Language Services in the Office of the Mayor. The New York City Office of Language Services provides technical assistance to each City agency for increased service delivery to limited-English speakers. There are approximately 2000 employees from all New York City agencies who volunteer as interpreters. These volunteers are listed in the NYC Language Bank Directory.

The NYCDH's language bank includes the following number of volunteers and their languages: Amjaric (2), Arabic (3), Armenian (1), Bengali (1), Chinese (3), Creole (4), Dutch (1), French (5), German (2), Greek (2), Gujarati (1), Hebrew (1), Hindi/Hindustani (6), Hungarian (1), Italian (5), Khmer (1), Marathi (2), Punjabi (2), Romanian (1), Russian (1), Serbo-Croatian (1), Spanish (18), Ukrainian (1), Urdu (2), and Yiddish (2).

Requests for emergency translation and/or interpretation are matched to the NYCDH's language bank volunteer roster. The volunteer's supervisor is contacted and the volunteer is then placed in communication with the requesting bureau.

Volunteers receive a one-half day training course covering issues and barriers encountered in health translation and interpretation. Upon completion of the training, volunteers are officially available for service.

The Language Sensitivity Training Program has recently been developed by the New York City Office of Language Services, the Office of Operations, and other New York City agencies. This instructional program has a training seminar, produced a brochure describing methods of dealing appropriately with clients who have limited-English speaking ability, and has produced a training video that describes everyday employee-client relations.

PERSONNEL

Current CCAO staff is multilingual/multicultural, and includes one Hispanic/Latina director, two Hispanic/Latino bilingual/bicultural assistants (one full-time and one part-time), and two bilingual/bicultural Chinese summer interns. With the exception of the director, all staff members are classified as temporary.

LESSONS LEARNED

CCAO has done considerable work in developing health campaigns for NES populations. CCAO operates on a modest budget and aggressively deals with the impact of cross-cultural issues in access to health care and health education. The work is especially important because issues of cross-cultural appropriateness are still being studied, refined and assessed for their applicability not only to NES populations, but to all minority communities.

The CCAO would like to do additional collaborative work with other agencies in such areas as cross-cultural training for interpreters and bilingual staff located in NYCDH clinics. While many clinics have bilingual staff members, CCAO is not currently connected to them nor involved with them in cross-cultural training. There is no overall policy and the hiring of bilingual staff is currently left up to each individual personnel department.

A formal evaluation in the area of service delivery to NES populations should be conducted. A needs assessment might be the most efficient measuring tool, but would entail additional staff and resources not currently available.

CITY AND COUNTY OF SAN FRANCISCO

Director of Public Health: Raymond J. Baxter, Ph.D

DEPARTMENT OF PUBLIC HEALTH

101 GROVE STREET

SAN FRANCISCO, CALIFORNIA 94102

(415) 554-2666

- **Robert N. Ross Patient Education Resources Center**
- **Central American Patient Advocate Program**
- **Bilingual Services Program**

SUMMARY

According to the 1990 Census there are approximately 35,000-40,000 legally-documented refugees from Southeast Asia, Ethiopia, Central Europe, and the former Soviet Union living in San Francisco. An estimated 50,000-60,000 undocumented persons from Central America are residing in the metropolitan San Francisco area. Another 5,000-10,000 immigrants, primarily from Asia, enter San Francisco each year.

This case profile describes the features of each of the language service units within San Francisco's General Hospital, and highlights the nationally-recognized Robert N. Ross Patient Education Resource Center -- a clearinghouse for easy-to-understand health education materials in the many languages spoken by residents of San Francisco. The language service programs described are the Central American Patient Advocate Program, the Bilingual Services Program, Multiethnic/Multilingual Psychiatric Services, and Cross-Cultural Training.

In Appendix #4 (pages 104-105) there is a summary of issues and recommendations related to language services issued by the Refugee and Immigrant Task Force in February 1992.

BACKGROUND

Barriers to accessing services due to language were first raised as an issue at the San Francisco Department of Public Health in 1978 when Hispanic/Latinos and Chinese filed an administrative complaint against the City and County of San Francisco, alleging that San Francisco General Hospital (SFGH) was not providing adequate bilingual services for their two language groups. The Office of Civil Rights (OCR), part of the Department of Health and Human Services, was charged with taking remedial action.

The Language Services Advisory Committee to the Department of Public Health was formed to remedy the situation outlined by the OCR complaint. The group functions as a subcommittee of the Refugee and Immigrant Health Task Force, and this interagency group continues to monitor language access in all public health facilities.

In 1989, a second access complaint was filed against SFGH via the Office of Civil Rights demanding that the hospital sign an agreement containing 15 actions it would take to improve language access. This second agreement concerned baseline language services for Vietnamese, Cambodian, Filipino, and Russian speakers and also required that signs be placed in SFGH to inform clients of the availability of interpreter services.

In 1983, 600 nurses were surveyed to determine what the barriers were to providing health education to patients. Nursing staff identified two main barriers: the inability to speak patient languages, and the lack of bilingual materials.

The findings led to the creation of the Robert N. Ross Patient Education Resource Center -- the flagship project for patient education services at SFGH. San Francisco General is one of the few hospitals in the country with a patient education unit. It functions as a department of SFGH and operates under the Associate Director for Patient and Community Relations.

Fluctuations in patient demand for language services are monitored through admissions intake forms which track patients in 25 languages. The primary foreign languages spoken by clients are Spanish and Chinese/Cantonese. In 1983 the main languages were Spanish and Cambodian but as the refugee population has become integrated into the health care system through the medical campus refugee clinic, the need for Cambodian has nearly disappeared.

ROBERT N. ROSS PATIENT EDUCATION RESOURCE CENTER

Structure

The Robert N. Ross Patient Education Resource Center (PERC), established in 1983, is a project of the Education Unit of San Francisco General Hospital.

PERC is designed to increase access to health information for people with low literacy skills and for those who do not speak English as a first language. The PERC collection contains materials developed by SFGH staff, information about the many programs of the San Francisco Department of Health, and materials collected from other public and private sources. The PERC collection includes materials in 15 languages and in 28 major subject areas. There has been a greatly increased demand recently for language materials in Russian and Arabic.

According to PERC staff, materials accepted for the PERC collection must:

- be medically accurate;
- be available in English and at least one other language;
- be easy to read (defined as 7th grade reading level or under);
- have graphics that reflect the population; and,
- be cheap or free.

PERC staff have developed guidelines for translating health education materials. These are summarized in Appendix #4, page 106 (Guidelines for Translating PERC Health Education Materials).

Languages

Amharic, Cambodian, Chinese, English, Khmer, Korean, Laotian, Polish, Russian, Spanish, Tagalog, Tigrinyan, Vietnamese.

Major Subject Areas

AIDS, Arthritis, Cancer, Dental Health, Dermatology, Diabetes, Family Planning, Gastrointestinal, Gynecology, Health Promotion, Heart, Hypertension, Infectious Disease, Legal, Medication, Mental Health, Neurology, Nutrition, Obstetrics, Occupational Health, Orthopedics, Pediatrics, Respiratory, Safety, Sexually Transmitted Diseases, Substance Abuse, Surgery, Urology.

Client Population

The target population for PERC's services consists exclusively of hospital clients, primarily low income whose first language is not English. While not all hospital and system users have low education levels, materials are developed for 7th grade reading level.

Demand has increased for the use of PERC materials from other public and private community-based programs all over the country, and from foreign countries as well. PERC has a working relationship with clinics from countries such as El Salvador, Nicaragua, and Nigeria. Requests from Nicaragua on OB/GYN-related education have been in great demand.

Activities

PERC staff provide ongoing training to clinics and nursing staff on how to use and access materials at the resource center. Each clinic and nursing unit also houses sub-collections of the materials available at PERC.

Personnel

Historically, staffing at PERC has been uneven. It has primarily consisted of health educators and nurses. Currently it is staffed by a part-time director, and one-and-a-half nurses who serve as health educators. One is a trainer with skills in adult medical care and AIDS and the other is skilled in adolescent health, substance abuse, sexually transmitted diseases and GYN. There is one half-time administrative assistant who is also in charge of inventory. Between 200-400 hours of volunteer time (mainly through graduate and undergraduate students) are donated each year. Volunteers average 4 hours a week at PERC helping with materials development.

Marianne Balin, Assistant Hospital Administrator, indicates that staffing is seriously inadequate. A more ideal staffing pattern would include a full-time health educator and nurse exclusively devoted to the project to work on materials update and development, and a full-time administrative assistant to do order fulfillment, inventory, and correspondence.

Resources

The annual cost for operating PERC is estimated at \$180,000 with its current core staff. PERC is financed through the hospital's budget.

According to staff, a more ideal budget would be \$245,000 to cover the additional costs of hiring one full-time administrative assistant, and one full-time assistant health educator.

OTHER SAN FRANCISCO LANGUAGE SERVICE PROGRAMS

The Central American Patient Advocate Program

The Central American Patient Advocate Program began in 1990 as a volunteer effort using individuals trained as community health promoters by the Good Samaritan Community Center. In March of 1991, funds were made available through the state Immigrant Public Health Fund. Health promoters assist patients with basic orientation to the hospital and public health care system, handle questions and complaints, locate clinics, support services, and other hospital offices, and facilitate referrals to programs outside the hospital.

Advocates are available Monday-Friday, 8:30 AM-5:00 PM to assist patients in the Outpatient and Emergency Departments of SFGH. Although the Advocates' primary focus is assisting monolingual Spanish-speakers, they assist any patient. They do not provide interpretation for medical encounters but may do limited interpretation that is related to their work.

Bilingual Services Program

The Bilingual Services Program serves as the focal point for language interpretation services at SFGH. The program has twelve full-time-equivalent employees who provide clinical interpretation in exam rooms and assist with billing and eligibility determination. Services are provided 18 hours a day, 7 days a week. Prior to employment staff members must pass a bilingual proficiency exam. Once hired they enter a specialized training program provided by SFGH.

The bilingual services program may also access other personnel drawn from a pool of "designated bilingual employees" to serve as interpreters. Designated bilingual employees are certified by the City under a system-wide program which grants bilingual eligibility status to Department of Public Health employees who "in performing their duties and attending to the public regularly use their non-English language ability 10 or more hours biweekly." Employees who pass a proficiency exam and who are selected to serve as "designated bilingual employees" are eligible, in accordance with the City's Salary Standardization Ordinance, to receive minimal premium pay.

The use of designated bilingual employees in an interpreter capacity has its limitations. For example, medical interpreters need special skills training, which is currently not available. In addition, pulling a "bilingual designate" from his/her work station is always disruptive and usually means someone else is not receiving a service.

Training for nurses and other medical staff on how to use medical interpreters is also needed. According to Marianne Balin, Assistant Hospital Administrator, "the medical interpreter is an important part of the medical services triangle, yet [medical staff] never get training on how to use this service effectively, nor interact with the interpreter." In her experience, physicians have to learn on-the-job and often have many questions about what to do.

Other Specialized Multiethnic/Multilingual Services

Within the psychiatric unit of SFGH there are several ethnic/language-specific in-patient programs. These include two specialized Asian and Latino psychiatric units, one Black, one women's unit and one AIDS unit. These units provide for the specific needs of ethnic minorities with appropriate food, holiday observances and bilingual staffing sensitivities. The Asian component has received significant national attention.

Cross-Cultural Training

In-service training in cross-cultural and language services for hospital staff is conducted by personnel within PERC, occasionally augmented by outside organizations and consultants. Training is provided by PERC staff in two areas: patient-education skills for low-literate multicultural populations, and the development of materials for low-literate, multilingual clients.

Training has also been provided by outside consultants on how to manage multicultural staff. In addition, a monthly mental health seminar with a Hispanic/Latino focus, sponsored by the San Francisco Department of Public Health, is available to employees.

LESSONS LEARNED

In 1991, the Language Services Advisory Committee undertook a review of San Francisco's five district health centers. A series of scheduled on-site visits was conducted by Committee members, with participation from health center staff, to discuss in detail the bilingual needs of each health center.

The Committee's report was issued in February 1992. Excerpts can be found in Appendix #4, pages 104-105. While some of the issues and recommendations relate specifically to bilingual services at SFGH, most recommendations apply to San Francisco's five district health centers.

REFUGEE HEALTH CARE PROGRAMS

- PORTLAND, OREGON
- SEATTLE, WASHINGTON
- CHICAGO, ILLINOIS

SUMMARY

Refugee health programs have undergone dramatic changes since 1975. The major initial concern of refugee health was screening, and while screening remains important, the Federal program emphasis has since shifted to address adequate funding, the availability of follow-up medical treatment and related health services, the availability of culturally-appropriate mental health services, and making trained bilingual/bicultural medical interpreters available in health care situations. These issues have grown in importance as refugee health issues have become more complex and diverse.

The refugee population in America's cities has increased dramatically in size as well as diversity. For example, Portland has refugees from Cambodia, Laos, Vietnam, China, Afghanistan, Ethiopia, Iran, Poland, Romania, and the former Soviet Union. The multiethnic backgrounds of these refugees has hindered their integration into LHD systems. Language barriers are one of the largest problems. Common complaints among health professionals and refugees alike include difficulties in establishing appointments, the lack of trained interpreters to help clients explain their symptoms, and to comprehend medical terminology and treatment instructions.

Cultural beliefs and values strongly influence the under-utilization of health care services among refugees. For example, a cultural value cherished by Southeast Asians is the ability to conceal pain. In American society, people respond only to what is expressed. Unexpressed health needs are therefore not known to providers and consequently not addressed. One such need, consistently neglected, has been refugee mental health.

The three refugee programs profiled here are examples of how refugees receive health care in the United States. These particular programs demonstrate the importance of shared financial assistance, bilingual/bicultural translators, and a specialized clinic that offers a culturally-connected environment.

BACKGROUND

Changes in immigration policy during the past few years have increased the challenges to providing culturally and linguistically appropriate health care at the local level. The refugee population is more diverse today than at any time in history and refugees come from every continent in the world. There are over 400 languages and dialects (as defined by the 1990 Census) spoken by people in need of health care in the United States.

The needs are growing, but so are the budgetary constraints. These constraints threaten the resources that are essential to maintain the vitality of refugee health programs, to retain trained bilingual/bicultural medical translators, to provide cross-cultural training programs for health care providers,

and to provide centralized services in a location that is accessible by public transportation.

Some of the problems that refugee health clinics encounter are: the lack of bilingual/bicultural staff; the lack of information about each patient's medical history so as to provide quality care in a non-specialized medical facility; the lack of space; the lack of appropriate translators as the flow of refugees changes; the lack of an appropriate method to insure a refugee's appearance at the clinic; and the issue of confidentiality of refugee records used for other than medical purposes.

MULTNOMAH COUNTY HEALTH SERVICES DIVISION

12710 SE Division

PORTLAND, OREGON 97236

INTERNATIONAL HEALTH CLINIC (IHC)

IHC Director: Dr. Bruce Bliatout

(503) 248-3149

STRUCTURE

The Multnomah County Health Services Division (MCHD) initiated refugee health services in 1975, when the first group of Southeast Asian refugees arrived, and established the Indochinese Refugee Health Clinic. Renamed in 1989 as the International Health Clinic (IHC), this facility, located in northeast Multnomah County, serves as the focal point for health screening and primary health care services to Portland's estimated 27,000 refugees. The IHC is operated by the Specialty Care Bureau of MCHD. Since 1990, newly-arrived refugees have been eligible to receive services from the IHC for a period of 8 months. After the 8 month period, the refugee client can choose to receive primary care from one of 15 County health clinics.

CIENT POPULATION

According to 1990 Census figures, there are more than a dozen different ethnic groups that comprise the refugee population in metropolitan Portland: Afghan, Cambodian, Czechoslovakian, Haitian, Hmong, Hungarian, Iranian, Lao, Mien, Pakistani, Polish, Romanian, Russian, Somalian, and Vietnamese. They are a diverse group in terms of educational background, socioeconomic status, and level of acculturation. The refugee population ranges from resettled "first wave" Vietnamese to recently-arrived highly-educated people from the former Soviet Union.

ACTIVITIES

Health Screening and Follow-up

The IHC provides health screening and primary care services to refugees referred by volunteer refugee service agencies which assist them in their resettlement. Almost all refugees receive health screening and follow-up care within 30 days of arrival in Oregon. These services include child/adult immunization, dental screening, health education, limited physical examinations, TB screening and referral to other County health clinics.

Interpretation

The IHC's services are provided with medical interpretation. Current interpretation service data from 1992 indicates 4,550-4,600 service calls are received per month. There is a shift underway from the medical worker/interpreter model to the bilingual/bicultural medical staff model. Dr. Bruce Bliatout, the program director, believes "the medical worker/interpreter model is somewhat outdated. Trained bilingual/bicultural medical personnel would allow clients to feel more comfortable in clinic settings."

Case Management

All screened refugees are assigned to a case manager who observes and follows their screening follow-up care and determines if the clients have needs additional to those for which treatment is available at the IHC. In these in-patient situations the IHC provides interpretation for the refugee client.

PERSONNEL

There are 12 full-time interpreters located at the IHC and a total of 27 full-time LHD interpreters countywide. In addition, there is an available pool of 80-85 on-call interpreters who are contracted through the International Refugee Center of Oregon for any additional interpreter needs.

The IHC has a staff of forty-five, which includes doctors, nurses, nurse-practitioners, and office assistants. New staff that have one-to-one contact with refugees receive cross-cultural instruction as part of their orientation.

RESOURCES

The IHC is funded by the Oregon Department of Public Health under a grant from the Department of Health and Human Service's Office of Refugee Resettlement. In addition, minimal funding from the Centers for Disease Control provides for TB screening and treatment.

SEATTLE/KING COUNTY HEALTH SERVICES DIVISION

2124 4TH AVENUE

SEATTLE, WASHINGTON 98121

REFUGEE SCREENING AND MEDICAL INTERPRETER SERVICES

Refugee Program Coordinator: Shari Wilson

(206) 296-4744 or 4755

STRUCTURE

The Seattle/King County Health Services Division (SKCHSD) provides medical interpretation with health screening and primary care services to refugees. The health department has 9 primary care clinics and one TB clinic. A multilingual team provides initial health screening for refugees during the first 4-6 weeks of their arrival, including testing for communicable diseases and other medical/

dental problems, referral to appropriate resources for continued care of identified problems, and medical interpretation and patient advocacy to access health care.

Newly-arrived refugees are primarily settled by a Volunteer Agency (VOLAG) Refugee Resettlement Program. VOLAGs handle appointments for refugees and their families at the Refugee Health Screening Project (RHSP).

CLIENT POPULATION

The client population includes any individual designated by the Immigration and Naturalization Service as a refugee. LHD client demographics indicate at least a dozen different ethnic groups that make up the local refugee population. They are: Cambodian, Ethiopian, Hmong, Lao, Mien, Russian, Somalian, Vietnamese, and others. In 1991, approximately 2600 refugees were served. In addition, the health department is currently in the process of collecting data on limited/non-English speaking populations served by other LHD clinics.

ACTIVITIES

The Refugee Health Screening Project provides services in child/adult immunization, interpretation, limited physical examinations, medical history, TB and hepatitis B screening, and referral to other community and LHD clinics.

Refugee screening is conducted at two of the 9 clinics. Eighty to ninety percent of all refugees arriving in King County are eligible for Aid to Families with Dependent Children (AFDC) and receive Medicaid. Single or childless refugees (10-20%) are eligible for the Refugee Cash and Medical Assistance Program, which provides help for only 8 months.

The interpreter services program is currently being evaluated. A survey in 1991 was administered to the entire health department to determine client language needs and the capability of staff to provide appropriate language services. The languages in order of highest demand were Spanish, Vietnamese, Russian, Cambodian, Amharic, Tigrinyan, and Somalian. One of the biggest problems with the on-call interpreter system was the inadequate coordination of scheduling.

PERSONNEL

The staff consists at present of six full-time interpreters who speak nine Southeast Asian languages, one Russian interpreter, a nurse practitioner, a doctor, and a registered nurse. An additional 50 interpreters are on-call to provide interpretation to refugees from the former Soviet Union, Eastern Europe, Spanish-speaking countries, South Asia, Southeast Asia, the Middle East, and Africa.

RESOURCES

The Refugee Health Screening Project is funded by the Washington Department of Public Health, which in turn is funded from the Federal Office of Refugee Resettlement. In addition, minimal funding is received from the Centers for Disease Control to provide for TB screening and treatment.

**UPTOWN NEIGHBORHOOD HEALTH CENTER
CHICAGO DEPARTMENT OF HEALTH
845 W. WILSON AVENUE
CHICAGO, ILLINOIS 60640**

**REFUGEE HEALTH PROGRAM (RHP)
RHP Health Administrator: Joan Nigh
(312) 744-4281 or 6588**

STRUCTURE

Illinois is among the top ten refugee-receiving states in the nation. In addition to large numbers of Southeast Asian refugees, which began arriving in the late 1970's, the City of Chicago has the second largest Polish community outside Warsaw. Chicago also reports a recent and growing influx of refugees from the former Soviet Union, Romania, and Iraq.

The Refugee Health Program (RHP), established in 1981, serves as the main point of entry into the public health system for refugees in Chicago. It is part of one of the largest public health departments in the nation, the Chicago Department of Health. Since the refugee health screening program began, over 27,000 refugees from 50 countries have received services through the RHP.

The Uptown Neighborhood Health Center has become the largest medical facility in the City's health department network and serves as the primary source of referral for the large refugee community. Linkages to organizations such as the American Refugee Committee in Evanston, the Illinois Refugee Social Services Consortium, the Chicago Coalition for Immigrant and Refugee Protection and the network of hospitals and other health care providers offering extended medical care when needed, provide a strong foundation for activity and advocacy for the well-being of refugees.

CLIENT POPULATION

Refugees from over twenty-five different ethnic groups were served by the RHP in 1991, from Afghanistan, Cambodia, Czechoslovakia, Haiti, Hungary, Ethiopia, Iran, Iraq, Laos, Pakistan, Poland, Romania, Russia, Somalia, and Vietnam, among others.

Since 1981, the top five major ethnic refugee groups seen by RHP were Vietnamese, Cambodian, Polish, Romanian and Assyrian.

ACTIVITIES

Chicago's refugee program provides health screening services to all refugees within 30 to 90 days of their arrival. For refugees previously diagnosed with medical problems requiring treatment and/or medicines, the RHP tries to see them within seven days of arrival.

Services provided at the RHP include laboratory, X-ray, immunization, dental, vision, hearing screening, and pharmacy services, as well as adult, pediatric and maternal care. Also available are a TB clinic, WIC program, HIV/AIDS primary care and STD clinic services.

PERSONNEL

The availability of trained bilingual/bicultural staff is one of the greatest sources of strength in the RHP program, for it ensures the correct transfer of medical information between patient and medical provider.

Many of the RHP's staff were medical professionals in their countries of origin. Currently, RHP has one foreign-born-and- trained medical director who has been with the clinic since it opened; two clinic nurses (both former refugees); eleven translators; a laboratory technician from Thailand; a TB clinic clerk from Ethiopia, and one infectious disease investigator from the Southeast Asian community. In addition, RHP works with professional physicians, many of whom are former refugees. A total of 39 languages are spoken at the clinic.

TRAINING

Bilingual/bicultural staff are initially trained for four to six weeks at an off-site Chicago Department of Health facility. The training covers the Chicago Department of Health's policies, procedures, programs, and the medical forms that staff will need in order to provide comprehensive follow-up medical care to refugee clients.

In addition, the American Refugee Committee provides specially designed workshops to increase staff assessment skills in both mental health and social service delivery.

The Chicago Department of Health, in collaboration with other organizations, sponsors medical information updates in the areas of immunization, hepatitis B, TB, parasites, confidential HIV counseling and testing, and HIV primary care. RHP coordinates with the Chicago Fire and Police departments to offer community education classes for refugees on fire safety and protection issues.

RESOURCES

A health physical and screening for a refugee at RHP costs nearly \$600, which does not include any treatment costs. Only \$270 is reimbursed to the City by the Federal Office of Refugee Resettlement, through the Illinois Department of Public Aid. The City estimates that over the past ten years it has spent in excess of \$8 million for refugee screening alone.

Other sources of support for the RHP include the Illinois Department of Public Health, the Illinois Department of Public Aid, and the Centers for Disease Control (through its Refugee Health Aid Program, TB Support Program and Hepatitis B Service Grant).

LESSONS LEARNED

According to the RHP administrators, current Federal proposals call for the privatization of certain services, which would result in severe funding cutbacks for the RHP and threaten the viability of the specialized Refugee Medical Screening Program.

Staff needs are particularly acute for HIV/AIDS services where demand is almost twice the rate available. Most urgently needed are medical specialists (multilingual laboratory technicians, pharmacists, nurses and field outreach workers). Salary incentives are also needed systemwide, but especially for clinic staff.

Much of RHP's success can be attributed to the following elements:

- Leadership is provided by bilingual/bicultural medical staff, many of whom have been with the RHP since it opened;
- Emphasis is placed on recruiting former refugee health care outreach workers and licensed medical professionals who ensure cultural connectedness in service delivery; and,
- The clinic is able to combine Federal, state and local resources to develop an integrated health screening and primary care services program.

Refugee health needs have changed and become more complex with each different "refugee wave." The refugee population has become more diverse than ever, ethnically, culturally and linguistically. Needs are greater than ever before, yet services to meet those needs appear to be diminishing. Refugee program funding in the Federal budget for the 1993 fiscal year faces a cut of 45 percent.

The refugee programs described above have been very successful. They were established to meet demonstrated needs for multicultural and multilingual health staff, and for multicultural and multilingual interpreters in medicine and mental health. How to maintain and, where necessary, expand those programs and to find the resources necessary to do so are major challenges for public policy.

APPENDICES

APPENDIX #1: BIBLIOGRAPHY

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APPENDIX #2:

LOCAL HEALTH DEPARTMENT SURVEY RESPONDENTS

ALABAMA

BIRMINGHAM
DOTHAN
MOBILE

ALASKA

ANCHORAGE

ARIZONA

FLAGSTAFF
PHOENIX
TUCSON

CALIFORNIA

EL CENTRO
FRESNO
LONG BEACH
LOS ANGELES
SACRAMENTO
SAN DIEGO
SAN FRANCISCO
SAN JOSE
SANTA ANA
SANTA CLARA

COLORADO

BOULDER
DENVER
ENGLEWOOD
FT. COLLINS
PUEBLO

CONNECTICUT

HAMDEN
WATERBURY

DISTRICT OF COLUMBIA

WASHINGTON

FLORIDA

DAYTONA BEACH
FT. LAUDERDALE
FT. MYERS
FORT WALTON
MIAMI
NEW PORT RICHEY
SANFORD
SARASOTA
ST. PETERSBURG
WEST PALM BEACH

GEORGIA

AUGUSTA
DECATUR
SAVANNAH

IDAHO

BOISE
COEUR D'ALENE
LEWISTON

ILLINOIS

ARLINGTON HEIGHTS
DES PLANES
MORRISON
PEORIA

ILLINOIS

ROCKFORD
ROCK ISLAND
ROCKLAND
SKOKIE
TREMONT
WHEATON
WOODSTOCK

INDIANA

RICHMOND

IOWA

IOWA CITY
WATERLOO

KANSAS

LAWRENCE

KENTUCKY

LOUISVILLE
SOMERSET

LOUISIANA

NEW ORLEANS

MASSACHUSETTS

BOSTON
CAMBRIDGE
CHICOPEE
FALL RIVER
MALDEN
NEW BEDFORD

MARYLAND

BALTIMORE
BEL AIR
LA PLATA
ROCKVILLE
TOWSON

MAINE

PORTLAND

MICHIGAN

ANN ARBOR
BATTLE CREEK
CHARLOTTE
DETROIT
FLINT
HOLLAND
MIDLAND
MONROE
MT. CLEMENS
MT. PLEASANT
NEGAUNEE
PORT HURON
WESTLAND

MINNESOTA

BENSON
DULUTH
MINNEAPOLIS
ST. PAUL

MISSOURI

HILLSBOROUGH
INDEPENDENCE (COUNTY)
ST. JOSEPH
ST. LOUIS (CITY)
ST. LOUIS (COUNTY)

MONTANA

KALISPELL

NEBRASKA

OMAHA

NEW HAMPSHIRE

NASHUA

NEW JERSEY

BRIDGETON
CLIFTON
SALEM
TOMS RIVER
VINELAND

NEW YORK

BELLMONT
FONDA
HAWTHORNE
ITHACA
LIBERTY
MINEOLA
MT. MORRIS
NEW YORK CITY
POMONA
SYRACUSE
UTICA
WATERTOWN

NORTH CAROLINA

ASHEVILLE
DURHAM
GREENSBORO
RALEIGH
SMITHFIELD
WILMINGTON
WINSTON-SALEM

OHIO

AKRON
CINCINNATI
COLUMBUS
DELAWARE
RAVENNA
YOUNGSTOWN

OKLAHOMA

OKLAHOMA CITY
TULSA

PENNSYLVANIA

ALLENTOWN
PITTSBURGH
WEST CHESTER

SOUTH CAROLINA

AIKEN
GREENVILLE

TENNESSEE

CHATTANOOGA
FRANKLIN
KNOXVILLE
MARYSVILLE
MEMPHIS

TEXAS

AMARILLO
AUSTIN
CORPUS-CHRISTI
DALLAS
FORT WORTH
HOUSTON (CITY)
HOUSTON (COUNTY)
LUBBOCK
ODESSA
SAN ANTONIO
SAN BENITO
TEMPLE
TYLER

UTAH

CEDAR CITY
OGDEN

VIRGINIA

ALEXANDRIA
ARLINGTON
CHESTERVILLE
FARMVILLE
FAIRFAX
LEBANON
MANASSAS
PORTSMOUTH
RICHMOND (CITY)
RICHMOND (COUNTY)
ROANOKE
SUFFOLK
VIRGINIA BEACH
WINCHESTER

WEST VIRGINIA

CLARKSBURG
HUNTINGTON

WASHINGTON

EVERETT

WISCONSIN

GREEN BAY
JANESVILLE
LA CROSSE
MILWAUKEE
RACINE

APPENDIX #3:

MULTILINGUAL HEALTH ASSISTANCE RESOLUTIONS ADOPTED JUNE 1992 BY THE UNITED STATES CONFERENCE OF MAYORS

WHEREAS, according to the U.S. Bureau of the Census, there are 26 language groups and nearly 400 different languages spoken in the U.S.; and

WHEREAS, non-English speaking people are most likely to have low socio-economic status and therefore are most likely to be unable to pay out-of-pocket for medical care and lack insurance, especially children and adolescents, and recently arrived immigrants; and

WHEREAS, the literature on health and mental health indicates that language is a major obstacle to access and the proper utilization of health services; and

WHEREAS, communication in health care is a complicated process that must take into account both language and cultural factors; and

WHEREAS, providers lack of knowledge and sensitivity about the culture and health behavior of non-English speaking people may result in stereotypes negatively affecting the provider-consumer relationship, and may have implications in service delivery and patient compliance; and

WHEREAS, lack of interpreter services and bilingual/bicultural staff in clinics and agencies that potentially serve non-English speakers is a barrier to access to health and mental health care for an increasing portion of the population; and

WHEREAS, interpreters require a great deal of skill to describe and explain terms, ideas and processes regarding patient care, and the lack of formal interpretation training may negatively affect the provider-consumer relationship; and

WHEREAS, the Public Health Service estimates that there are 35 million people who live in medically underserved areas where there are shortages of physicians and other health service professionals; and

WHEREAS, there exists a severe shortage of multilingual and multicultural health professionals such as physicians, nurses and other health providers; and

WHEREAS, limited data on the health care status of non-English speaking persons exists at the local, state and federal level, and research and factors that facilitate the provision of bilingual assistance; and

WHEREAS, the Disadvantaged Minority Health Improvement Act requires that providers receive assistance from bilingual health professionals in the provision of services regarding maternal and child health, nutrition, mental health, and substance abuse; and

WHEREAS, there is a need for technical support and guidance from the federal government regarding the implementation of bilingual assistance activities at the local level,

NOW, THEREFORE, BE IT RESOLVED, that The U.S. Conference of Mayors calls on the Department of Health and Human Services to establish guidance to maximize outreach and access to health services for non-English speaking persons; and

BE IT FURTHER RESOLVED, that the Conference of Mayors calls on Congress and the Administration to increase an emphasis on and funding for multilingual health assistance activities aimed at building local capacity to serve non-English speaking persons; and

BE IT FURTHER RESOLVED, that Congress increase Public Health Service appropriations to provide for cross-cultural training and to increase cultural competence among local health care providers; and

BE IT FURTHER RESOLVED, that the Public Health Service should identify, promote, and fund model programs that effectively address linguistic barriers to health care, and that the necessary technical assistance be made available for the development and replication of successful programs.

APPENDIX #4:

SUMMARY OF SAN FRANCISCO LANGUAGES SERVICES ADVISORY COMMITTEE ISSUES AND RECOMMENDATIONS FEBRUARY, 1992

Issue: Interpreter Services

The number of filled interpreter positions at the hospital continually threatens to slip below minimally effective levels.

Recommendation: The committee recommended guarding against cutbacks in full time staffing for interpreter positions considered to be minimally effective.

Issue: Translation Services

Translation services are procured through a variety of means, often using non-professionals and failing to insure quality control over the finished product. There is a widespread and acknowledged need for a centralized policy and coordination of translation services throughout the department of Public Health.

Recommendation: The committee recommended development of an approved vendor list for translation services, the development of a quality control protocol, and identification of a fund for financing this need. A minimum of \$15,000 should be set aside for a pilot year of centralized translation effort from which all public health programs could draw for critical translation needs.

Issue: Bilingual Capability and Staffing

Bilingual capability and staffing have been particularly at issue in Health District #1 where approximately 40% of all Hispanics living in San Francisco reside.

Recommendation: Emphasize recruitment and retainment of bilingual, bicultural public health nursing staff so that staff capabilities accurately reflect clients' language and cultural needs; maintain adequate levels of public health nursing staff as these play vital roles in reaching, monitoring, and providing orientation to refugees and immigrants.

Issue: Culturally Appropriate Mental Health Services

Traumatic experiences of violence in refugee homelands exacerbated by their marginal status and cultural disorientation in their new home prove disabling and immobilizing. In addition, the construct of "mental health" treatable through clinical intervention is not shared by all newcomers. Mental illness has a particular stigma in Latin and Asian cultures.

Recommendation: The Task Force's recommendations aimed at increasing the flexibility of the department's delivery of mental health services. They emphasized collaboration with community

agencies, out-stationing of clinical personnel to community settings, and the use of paraprofessionals from immigrant and refugee communities in order to offer mental health services in a modality in which they can be accepted and used by newcomers. Specifically, these included:

1. A minimum of 4 hrs. training for all clinical personnel who work with newcomers to acquaint providers with experiences of war related trauma with refugees and familiarize them with the guises of Post-Traumatic Stress Disorder;
2. Increasing the number of clinical personnel out-stationed in community settings such as schools and social service agencies in order to better address the special needs of refugees and immigrants.
3. Increased support for professional staff to train and oversee the work of promoters in the Mental Health Promoter Training (MHPT) Program. This program trains lay people to work in their own communities to identify mental illness and make referrals.

**SAN FRANCISCO GENERAL HOSPITAL
PATIENT EDUCATION RESOURCE CENTER**

Guidelines for Translating Health Education Materials

Translating information into another language is a very special skill. It does not mean just translating each word literally. The finished product must be easy to read and understand at the educational level of the person reading it.

1. Keep the sentences short and to the point. Express only one idea in each sentence.
2. Use a simple sentence structure. Take out clauses.
3. Use short, commonly used words. Limit the number of words containing three or more syllables.
4. Explain words that you think would be unfamiliar to people reading the translation.
5. Use the same words consistently. (i.e., physician, doctor).
6. Don't use hyphens.
7. DON'T USE ALL CAPITAL LETTERS. IT IS HARDER TO READ.
8. Write in the active rather than the passive voice. (example: Say, "Take your medicine" rather than, "your medicine should have been taken.")
9. Use the second person, YOU, instead of the third person, such as "the patient" or "individuals".
10. Use the same format consistently so that the reader knows what to expect.
11. Evaluate your translation by interviewing a few people who have completed different grade levels to get their reactions. Do they like it? Do they understand it?

For further information on PERC materials, please contact USCLHO staff, Mizzette Fuenzalida, MHAP Manager at 202-293-7330.

APPENDICE #5
LOCAL HEALTH DEPARTMENT: STAFF AND CLIENT LANGUAGE USE

Health Department	Spanish	Chinese	Vietnamese	Cambodian	Hmong	French	Other
Alexandria, VA	•*		•*	•		•	•*
Allentown, PA	*						
Amarillo, TX	•						
Ann Arbor, MI	•*	*	*	*			
Anchorage, AK	•*						
Arlington, VA	•*		•*	•*		•	•*
Arlington Heights, IL	•*						*
Asheville, NC	•					•	
Augusta, GA	*		*				
Austin, TX	•*		•*				•*
Baltimore, MD	•*						•
Battle Creek, MI	*		*				*
Bel Air, MD	•*						
Belmont, NY	*						
Benson, MN	•*					•	
Birmingham, AL	•*		•				•*
Boise, ID	•*						
Boston, MA	•*	•	•	•		•	•*
Boulder, CO	•*		*	*	•*	•	•*

• Staff Language * Client Language
Source: 1992 USCM Multilingual Health Assistance Project Survey

LOCAL HEALTH DEPARTMENT: STAFF AND CLIENT LANGUAGE USE

Health Department	Spanish	Chinese	Vietnamese	Cambodian	Hmong	French	Other
Bridgeton, NJ	•*						
Cambridge, MA	•*						•*
Cedar City, NJ	*	*					*
Chattanooga, TN	•						
Chesterfield, VA	*		*	*			
Cincinnati, OH							*
Clarksburg, WV							*
Clifton, NJ	•*	*					*
Coeur D'Alene, IA	•*						*
Columbus, OH	•*						*
Corpus-Christi, TX	•*						
Dallas, TX	•*		*	*			*
Daytona Beach, FL	•*		•*			•	*
Decatur, GA	•*		•*	•*			•
Denver, CO	•*						*
Detroit, MI	•						•
Dothan, AL	*		*				
Duluth, MN					*		
Durham, NC	•					•	
El Centro, CA	•*						

• Staff Language * Client Language
Source: 1992 USCM Multilingual Health Assistance Project Survey

LOCAL HEALTH DEPARTMENT: STAFF AND CLIENT LANGUAGE USE

Health Department	Spanish	Chinese	Vietnamese	Cambodian	Hmong	French	Other
Englewood, CO	*						
Everett, WA	•						•
Fairfax, VA	••		••				••
Fall River, MA							•
Farmville, VA	••						
Flagstaff, AZ	••						••
Flint, MI	••						
Fonda, NY							
Fort Worth, TX	••	*	*				
Franklin, TN	*						*
Fresno, CA	••		•		••		*
Ft. Collins, CO	••	*	*	*		•	••
Ft. Lauderdale, FL	••					•	•
Ft. Myers, FL	••					••	
Ft. Walton, FL	••		*				••
Green Bay, WI	*				••		•
Greensboro, NC	••		*	*			
Greenville, SC	••		*			••	•
Hamden, CT	*						
Holland, MI	••		*	*			

- Staff Language * Client Language
- Source: 1992 USCM Multilingual Health Assistance Project Survey

LOCAL HEALTH DEPARTMENT: STAFF AND CLIENT LANGUAGE USE

Health Department	Spanish	Chinese	Vietnamese	Cambodian	Hmong	French	Other
Houston, (City) TX	•*		•*				
Houston, (County) TX	•*	*	•*			•	*
Independence, MO	•						
Janesville, WI						•	•
Knoxville, TN	*						
La Crosse, WI	*				•*		
Lawrence, KS						•	
Lebanon, VA	•*						
Lewiston, ID	•*						
Liberty, NY	•*						*
Long Beach, CA	•*		•*	*			•
Los Angeles, CA	•*	•*	•	•			•*
Louisville, KY	•*	*					•*
Lubbock, TX	•*						•*
Malden, MA							•
Manassas, VA	•*						•
Memphis, TN	•*		*	•	•		•
Miami, FL	•*					*	•
Milwaukee, WI	•*		•*		•*		•*
Mineola, NY	*						*

- Staff Language * Client Language
- Source: 1992 USCM Multilingual Health Assistance Project Survey

LOCAL HEALTH DEPARTMENT: STAFF AND CLIENT LANGUAGE USE

Health Department	Spanish	Chinese	Vietnamese	Cambodian	Hmong	French	Other
Minneapolis, MN	•	•	••	••	••		
Mobile, AL	•		••	••			*
Monroe, MI	*						*
Morrison, IL	*						
Mt. Clemens, MI	*						*
Mt. Morris, NY	*						
Mt. Pleasant, MI	*						*
Nashua, NH	••					••	••
New Bedford, MA	*						••
New Orleans, LA	••		*				
New Port Richey, FL	••	•	*				••
New York City, NY	••	••				••	••
Odessa, TX	••						
Ogden, UT	••	*					*
Oklahoma City, OK	••		••				
Peoria, IL	••	*	*				
Phoenix, AZ	••		••				•
Pittsburgh, PA							•
Pomona, NY	••					•	••
Port Huron, MI	••						•

• Staff Language * Client Language
Source: 1992 USCM Multilingual Health Assistance Project Survey

LOCAL HEALTH DEPARTMENT: STAFF AND CLIENT LANGUAGE USE

Health Department	Spanish	Chinese	Vietnamese	Cambodian	Hmong	French	Other
Portland, ME	*						
Portsmouth, VA	•*						•
Pueblo, CO	•						
Racine, WI	*						
Raleigh, NC	•*	*	•*			•	•*
Ravenna, OH	•*						
Richmond, IN	•						
Richmond, (City) VA	•*						•*
Richmond, (County) VA	•*	•	•*	*			*
Roanoke, VA	•*		•*				•
Rockford, IL	•		•				
Rockland, IL	•						
Rockville, MD	•*	*	•*	•			•*
Sacramento, CA	•*	•	*				•*
Salem, NJ	•*						•*
San Antonio, TX	•*						
San Benito, TX	•*						
San Diego, CA	•*		*	*	*		
San Jose, CA	•*	•	•*	•			•
San Francisco, CA	•*	•*	•*		•		•

• Staff Language * Client Language
Source: 1992 USCM Multilingual Health Assistance Project Survey

LOCAL HEALTH DEPARTMENT: STAFF AND CLIENT LANGUAGE USE

Health Department	Spanish	Chinese	Vietnamese	Cambodian	Hmong	French	Other
Sanford, FL	•*		*				
Sarasota, FL	•*	•	•*				
Santa Ana, CA	•						
Savannah, GA	*		•*				*
Smithfield, NC	*						
Somerset, KY							
St. Joseph, MO	*						*
St. Louis, (City) MO	•*		*				•*
St. Louis, (County) MO		•	•				
St. Petersburg, FL	•		•	•		•	•
St. Paul, MN	•	•	•*	*	•*	•	•
Syracuse, NY	•	•					•
Temple, TX	•*						•*
Toms River, NJ	•					•	
Tucson, AZ	•*						
Tulsa, OK	•*	*	*	*			•
Tyler, TX	•*						
Vineland, NJ	•*						*
Virginia Beach, VA	•*		*	*			•
Utica, NY	*						

• Staff Language * Client Language
Source: 1992 USCM Multilingual Health Assistance Project Survey

LOCAL HEALTH DEPARTMENT: STAFF AND CLIENT LANGUAGE USE

Health Department	Spanish	Chinese	Vietnamese	Cambodian	Hmong	French	Other
Washington, DC	•*	•*					
Waterbury, CT	•*						*
West Chester, PA	•*		•*				•*
Westland, MI	•*						•*
West Palm Beach, FL	•*						*
Wheaton, IL	*	*	*				*
Wilmington, NC	•*						•
Winchester, VA	•*	*	*				*
Winston-Salem, NC	•*						
Woodstock, IL	*						
Youngstown, OH	•*						

• Staff Language * Client Language
Source: 1992 USCM Multilingual Health Assistance Project Survey

APPENDIX #6:
LHD STAFF LANGUAGE CAPABILITY, OTHER LANGAUGES

1. Alexandria	Arabic, Egyptian, Farsi, German, Italian, Portuguese, Tagalog
2. Amarillo	Laotian
3. Ann Arbor	Arabic, Russian, Swahili
4. Anchorage	Korean, Tagalog, Yupik
5. Arlington	Laotian
6. Asheville	American Sign, Greek
7. Augusta	Korean
8. Austin	American Sign
9. Baltimore	Greek
10. Bel Air	Sign
11. Birmingham	Bengali
12. Boston	Haitian Creole, Portuguese, Portuguese-Creole
13. Boulder	Russian
14. Cambridge	Haitian, Portuguese
15. Cedar City	Pinte Indian
16. Chicopee	Polish, Greek
17. Clarksburg	Japanese
18. Clifton	Polish, Ukrainian
19. Coeur D'Alene	Russian
20. Columbus	Japanese
21. Dallas	Laotian
22. Daytona Beach	French
23. Decatur	Laotian
24. Denver	Indochinese
25. Detroit	Arabic
26. Dothan	Japanese
27. Durham	Swahili
28. Everett	American Sign, Russian
29. Fairfax	Farsi, Korean, Urdu
30. Fall River	Polish, Portuguese
31. Flagstaff	Navajo
32. Fort Worth	German, Hungarian
33. Franklin	Kurd, Russian
34. Fresno	Laotian
35. Ft. Collins	German, Russian
36. Ft. Lauderdale	Creole, Greek, Romanian, Sindhi, Tagalog, Urdu
37. Ft. Myers	Creole, Burmese, Bengali, German, Portuguese
38. Ft. Walton Beach	Thai
39. Ft. Worth	German, Hausa, Swahili, Yoruba
40. Green Bay	Laotian
41. Greenville	German, Swedish

42. Janesville	German
43. Liberty	Dutch, Hebrew, Portuguese, Yiddish
44. Long Beach	Kamier, Laotian, Samoan, Tagalog
45. Los Angeles	Armenian, Korean, Laotian, Tagalog
46. Malden	Hebrew, Yiddish
47. Manassas	Italian, Hindustani, Tagalog
48. Miami	Creole
49. Milwaukee	Laotian
50. Mineola	Haitian, Portuguese
51. Minneapolis	Arabic, Ethiopian, Laotian, Polish, Russian, Thai
52. Mobile	Laotian
53. Nashua	Portuguese
54. New Bedford	Portuguese
55. New Port Richey	Greek, Haitian
56. New York City	Amharic, Arabic, German, Russian, and 19 other languages
57. Ogden	Japanese
58. Phoenix	Navajo
59. Pittsburgh	Polish, Russian
60. Pomona	Creole, Yiddish
61. Portsmouth	Tagalog
62. Raleigh	Korean, Polish
63. Ravenna	German, Indian, Italian, Japanese, Polish
64. Richmond	Russian, Spanish, Tagalog
65. Roanoke	Laotian
66. Rockville	French/Creole
67. Sacramento	Tagalog, Russian
68. Sarasota	Czechoslovakian, German, Hungarian
69. Salem	Korean, Tagalog
70. San Francisco	27 different Languages
71. San Jose	Tagalog
72. Sanford	Farsi, Portuguese, Tagalog
73. Santa Clara	Tagalog
74. St. Joseph	Ukrainian
75. St. Louis	Russian
76. St. Petersburg	German, Laotian
77. Syracuse	American Sign, Danish, German, Greek, Hindi, Italian, Korean, Macedonian, Polish, Russian, Serbo-Croatian, Ukrainian
78. Temple	Korean
79. Virginia Beach	Tagalog
80. Vineland	German
81. West Palm Beach	Canjabal, Haitian Creole
82. West Chester	Filipino
83. Westland	Arabic
84. Wheaton	American Sign
85. Wilmington	Farsi, Italian

APPENDIX #7: CULTURAL CHARACTERISTICS

General “cultural and communicative tendencies” as identified by Dr. Orlando Taylor

ASIAN AND PACIFIC ISLANDER AMERICANS

1. Strong family connections
 2. Respect for patience, owing to respect for history
 3. Preference towards modesty, reserve, and control
 4. Respect for silence
 5. Low regard for argumentation
 6. Respect for authority
 7. Orientation towards tradition
 8. Disrespect for aggression and aggressive behavior
 9. Orientation towards privacy
 10. Hesitancy towards spontaneity
 11. Highly structured society, with lots of “do’s and don’ts”
 12. Dropping of eyes to show respect
 13. Use of laughter when embarrassed
 14. Taking offense at use of nicknames or use of first name only
 15. Disdain for public reprimand
- (Taylor, 1989: 23)

HISPANIC AMERICANS

1. Unity and interdependence among members of the (extended) family
 2. Expectation that the family and extended family will care for the young and elderly
 3. Flexible sense of time
 4. Physical closeness and touching during conversation
 5. Emotional intensity and expression during conversation
 6. Respect for tradition and traditional family and social roles
 7. Preference for field-independent (social oriented) learning style
- (Taylor, 1989: 23)

APPENDIX #8:

1992 MULTILINGUAL HEALTH ASSISTANCE PROJECT NATIONAL ADVISORY GROUP

Delia Alvarez, Director of Public Health
County of Santa Clara, Department of Public Health
San Jose, California 95128
Tel: (408) 299-2301

Victoria Binion, Ph.D., Public Health Director
Detroit Health Department
Detroit, Michigan 48202
Tel: (313) 876-4300

Helen T. Chang, Assistant to the Mayor
City of Houston
Houston, Texas 77002
Tel: (713) 247-3595

Ms. Adela Gonzalez, Director
Dallas Department of Health & Human Services
Dallas, Texas 75201
Tel: (214) 670-5216

Margaret A. Hamburg, M.D., Acting Commissioner of Health
New York City Department of Health
New York, New York 10013
Tel: (212) 788-5261

Judith Kurland, Commissioner
Department of Health and Hospitals
Boston, Massachusetts 02118
Tel: (617) 534-5365

Annie R. Neasman, R.N., M.S., County Public Health Administrator
Dade County Health Department
Miami, Florida 33125
Tel: (305) 324-2400

Guadalupe Olivas, Ph.D., Health Director
Pima County Health Department
Tucson, Arizona 85701
Tel: (602) 740-8261

Shari Wilson, Coordinator: Refugee Health Services
Seattle-King County Department of Public Health
Seattle, Washington 98121
Tel: (206) 296-4744 or 4755

Steven Uranga-McKane, D.M.D., M.P.H.
Kellogg Foundation
Battle Creek, Michigan 49017
Tel: (616) 969-2023

Loren Ellery, Project Director/Research Analyst
American Indian Health Care Association (AICHA)
St. Paul, Minnesota 55101
Tel: (612) 293-0233

Cristina Lopez, Director of Health and Elderly Services
National Council La Raza (NCLR)
Washington, DC 20005
Tel: (202) 289-1380

Laurin Mayeno, Executive Director
Association of Asian/Pacific
Community Health Organizations (AAPCHO)
Oakland, California 94612
Tel: (510) 272-9536

Mary Thorngren, Director of Maternal & Child Health
National Coalition of Hispanic Health and Human Services Organization (COSSMHO)
Washington, DC 20036
Tel: (202) 387-5000



***The United States Conference of Local Health Officers/
The United States Conference of Mayors***

***1620 Eye Street, NW
Washington, DC 20006
202-293-7330***



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